Specific Guidance Documents for Congregate Living, Shelters & Other Settings

REVISED **A.** **Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites.** Source: AHS (June 10, 2020)

NEW **B.** **Congregate Living Settings - Recommendations for Cohorting Clients.** Source: AHS (May 8, 2020)

NEW **C.** **Congregate Living Settings - Recommendations for Cohorting Staff.** Source: AHS (May 8, 2020)

NEW **D.** **MOH Guidelines for Transfers, Discharges, and Admissions during COVID-19 Pandemic.** Source: AHS (May 13, 2020)

REVISED **E.** **Shelter Guidance: Preventing, Controlling and Managing COVID-19.** Source: AHS (June 9, 2020)

REVISED **F.** **COVID-19 Practice Guidance for Service Providers in Supported Independent Living, Group and Residential Care in Alberta.** Source: Alberta Children's Services (June 3, 2020)

NEW **G.** **COVID-19 Placement Resource Practice Guidance: Process to Meet Urgent COVID-Related Placement Needs.** Source: ACS (May 15, 2020)

REVISED **H.** **Child Intervention Practice Guidance COVID-19** (May 4) and **A Staged-in Approach to In-person Work** (May 29, 2020). Source: ACS

NEW **I.** **COVID-19 Guidance for Multi-family Dwellings and Apartment Buildings.** Source: GOA (May 23, 2020)

NEW **J.** **COVID-19 Guidance for Outdoor Events.** Source: GOA (June 9)

NEW **K.** **COVID-19 Guidance for Sport, Physical Activity and Recreation - Stage 2.** Source: GOA (June 12)

Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites

For the purposes of this document, “congregate” refers to settings where residents/clients receive care and/or services in a communal environment with other residents/clients.

June 2020

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Introduction

The purpose of this document is to provide current best-practice/evidence-based guidelines for COVID-19 outbreak control and management in congregate settings. Please note that this is only a supplemental addition to existing guidelines; more detailed descriptions of general outbreak control strategies are available in the Alberta Health Services (AHS) outbreak guidelines*:

- Guidelines for Outbreak Prevention, Control and Management in Acute Care and Facility Living Sites, July 2019
- Guidelines for Outbreak Prevention, Control and Management in Supportive Living and Home Living Sites, July 2019

*If there is conflicting information between these documents and the standards in the **Chief Medical Officer of Health (CMOH) Order 23-2020**, the standards supersede. For the purposes of this document, "congregate" refers to settings where residents/clients receive care and/or services in a communal environment with other residents/clients.

In addition, operators of licensed supportive living (SL) and long-term care (LTC) facilities in Alberta must follow the requirements set out in all Orders issued by the Chief Medical Officer of Health (CMOH), with particular attention to Order 14-2020 and Order 23-2020. *Italicized sections below are requirements for these facilities.* Other settings not explicitly covered by these Orders should also follow these recommendations where possible to limit the spread of COVID-19 in their vulnerable populations.

The notification of outbreaks and other infectious disease threats in Alberta is mandated under Section 26 of the provincial Public Health Act, and each Medical Officer of Health (MOH) is accountable for outbreak investigation and management (Section 29).

Early recognition and swift action is critical for effective management of COVID-19 outbreaks in congregate settings because of the increased risk of severe symptoms from COVID-19, and the increased risk of spread when vulnerable individuals live in close contact**.**

Contact the AHS Coordinated COVID-19 Response at 1-844-343-0971 about any symptomatic person in a congregate setting i.e., a symptomatic staff or resident/client that exhibits any symptoms of COVID-19 (see Table 1) at a site that does not already have a confirmed outbreak. Sites that do not already have a confirmed COVID-19 outbreak should continue to report newly symptomatic staff/residents/clients to the AHS Coordinated COVID-19 Response team.

Sites that have not yet been contacted by Public Health about a confirmed outbreak must report symptomatic staff/resident/clients that exhibit any symptoms of COVID-19 (see **Table 1)** promptly to the AHS Coordinated COVID-19 Response at 1-844-343-0971. They will be immediately provided with additional guidance and decision-making support, including access to Personal Protective Equipment (PPE) as necessary. The AHS Coordinated COVID-19 Response is also available to provide further assistance as needed if a site continues to see cases in staff or residents/clients UNLESS the site has already been contacted by Public Health to initiate a confirmed outbreak investigation in follow-up to a positive COVID-19 lab result. The Public Health team will ONLY be in contact with sites that have a confirmed outbreak to support outbreak management, prevention and control at that site.

Continuous masking: As per CMOH guidance, continuous masking became effective April 15, 2020 for licensed supportive living (SL) and long-term care (LTC) facilities as well as lodge accommodation. AHS has a guideline for continuous masking in health care workers who work in patient care areas, in addition to use of personal protective equipment (PPE) as part of droplet and contact precautions.

Staff, Infection Control Professionals (ICP)/Infection Control Designate (ICD) and Public Health professionals in congregate settings work collaboratively with facility administrators and staff to facilitate prompt response to help minimize the impact of the outbreak. For ongoing updates relevant to congregate settings, see https://connection.albertahealthservices.ca. Note - you will be required to register the first time you use the site.

***Note*:** This is not a comprehensive infection prevention and control (IPC) document. *Only the minimum updates necessary for managing outbreaks of COVID-19 are outlined here*. Please continue to use your AHS Guidelines for Outbreak Prevention, Control and Management for general information on outbreak management. For detailed information about IPC, please consult your ICP/ICD for your facility or Public Health.

CMOH Order 23-2020 provides information on outbreak prevention measures related to staffing, admissions/transfers, testing, essential workers, visiting restrictions and other details.

1. Principles of Outbreak Management

1.1 Surveillance

Conduct ongoing monitoring and surveillance for symptoms of COVID-19 (see Table 1) in staff and residents/clients and prompt identification of possible outbreaks.
Anyone with symptoms listed in Table 1 must be isolated and should be asked for consent to be tested for COVID-19. **Initiate appropriate testing, isolation and contact and droplet precautions promptly if a single staff or resident/client exhibits symptoms of COVID-19.**

- Sites that have symptomatic staff or residents/clients (see Table 1) must contact the AHS Coordinated COVID-19 Response at 1-844-343-0971 for guidance and support.
    - Note: for confirmed COVID outbreaks where Public Health is already involved in outbreak management, **do not** contact the AHS Coordinated COVID-19 Response line with newly symptomatic individuals.

1.2 Assessment

Assess staff and residents/clients for symptoms of COVID-19 (see Table 1).

(a) Symptomatic staff:

- Regardless of where exposure occurred, all staff with symptoms of COVID-19 (see Table 1) must immediately contact their manager/designate.
- *Staff that become symptomatic while at work must not remove their mask and must be sent home immediately by private transportation (i.e. not public transit).*
- Staff should use the AHS online self-assessment tool for Health Care Workers to arrange testing. Symptomatic staff are managed as per Workplace Health and Safety (WHS)/ Occupational Health and Safety (OHS)/Public Health recommendations for isolation and safe return to work.

(b) Symptomatic residents/clients

- Isolate immediately using droplet and contact precautions. Cohorting may be necessary when capacity issues and bed availability is a challenge.
- A resident within a shared room that is required to isolate should be moved to a private space, where possible.
    - Where this is not possible, residents should not be within 2 metres of each other and use of physical/visual barriers (e.g., curtains or portable wipeable screens) must be implemented at all times.
- Contact the AHS Coordinated COVID-19 Response at 1-844-343-0971 for an EI number prior to sending initial specimens for testing.
- For residents/clients that have symptoms of COVID-19 (see Table 1), arrange for specimen collection and testing as soon as possible.
- Follow IPC risk assessment for respiratory illness and implement contact and droplet infection prevention and control precautions and other outbreak strategies immediately, while waiting for test results.

1.3 Outbreak Identification

Initiate full outbreak management precautions as soon as one symptomatic staff/resident/client is identified.
One positive specimen result for COVID-19 in a resident/client/staff is a confirmed outbreak. Even when a COVID-19 case is identified and an outbreak is declared, obtain consent to continue testing all newly symptomatic staff and residents/clients throughout the outbreak until otherwise directed by Public Health. When there is a **new** confirmed COVID-19 outbreak, all residents/clients and staff in the affected site/unit should be asked to consent to testing for COVID-19.

- Testing of residents should ideally occur within 3 days of a confirmed case of COVID-19;

however, if it takes longer to obtain consent then testing may still occur at that time.

- Asymptomatic testing within licensed group homes is at the discretion of the AHS Zone MOH/designate, based on individual medical complexity and site circumstances.

Note: Re-testing of newly symptomatic residents/clients that are previously positive COVID-19 cases that have recovered should only be completed if there has been more than 30 days since their previous positive test, or if case-specific assessment with the MOH warrants re-testing.

Table 1: COVID-19 Symptoms to Initiate Testing

Residents* in Facility	***Staff in Facility***
• Fever (**37.8°C** or higher[1]) Any **new** or **worsening** respiratory symptoms: • Cough • Shortness of Breath/Difficulty Breathing • Runny Nose • Sneezing • Nasal Congestion/Stuffy Nose • Hoarse Voice • Sore Throat/Painful Swallowing • Difficulty Swallowing Any **new** symptoms including but not limited to: • Chills • Muscle/Joint Ache • Nausea/Vomiting/Diarrhea/Unexplained Loss of Appetite • Feeling Unwell/Fatigue/Severe Exhaustion • Headache • Loss of Sense of Smell or Taste • Conjunctivitis • Altered Mental Status **Resident/client list is expanded as they may experience milder initial symptoms or be unable to report certain symptoms*	• Fever • Cough • Shortness of Breath/Difficulty Breathing • Sore Throat • Runny Nose • Chills • Painful Swallowing • Stuffy nose • Headache • Muscle/Joint Ache • Feeling Unwell/Fatigue/Severe Exhaustion • Nausea/Vomiting/Diarrhea/Unexplained Loss of Appetite • Loss of Sense of Smell or Taste • Conjunctivitis
Note: individuals with fever, cough, shortness of breath, runny nose or sore throat, require 10 day mandatory isolation or until symptoms resolve, whichever is longer as per CMOH Order 05-2020.	

1.4 Outbreak Definition

Outbreak Definition

Confirmed COVID-19 outbreak[2]:

- *any one individual (staff/resident/client) laboratory confirmed to have COVID-19:*

NOTE: Even if a confirmed outbreak is identified, continue to collect and submit swabs for newly symptomatic individuals until otherwise directed by Public Health.*

- **Re-testing of newly symptomatic residents/clients that are previously positive COVID-19 cases that have recovered should only be completed if there is more than 30 days since their previous positive test, or if case-specific assessment with the MOH warrants re-testing.*

Early recognition of COVID-19 outbreaks is extremely important. Conduct ongoing surveillance of staff and residents/clients for early detection of COVID-19 cases/outbreaks. If test results are negative for COVID-19, usual influenza-like illness (ILI) or gastrointestinal illness (GI) outbreak protocols should be followed as appropriate.

Staff requirements: *To protect the most vulnerable Albertans, designated supportive living and long-term care staff employed or contracted by the operator are limited to working within one single designated supportive living or long-term care facility, regardless of outbreak status. This will help*

[1] Thermometer confirmed temperature is not required. If a resident feels they have a fever, offer testing.

[2] Sites with two or more individuals with confirmed COVID-19 will be included in **public reporting**.

to prevent the spread of illness between facilities.

In the case of a **confirmed** COVID-19 outbreak, all other congregate settings (i.e. non-designated licensed supportive living, lodges, and group homes) must require staff to work only at one congregate living setting for the duration of the outbreak as per *CMOH Order **23-2020***.

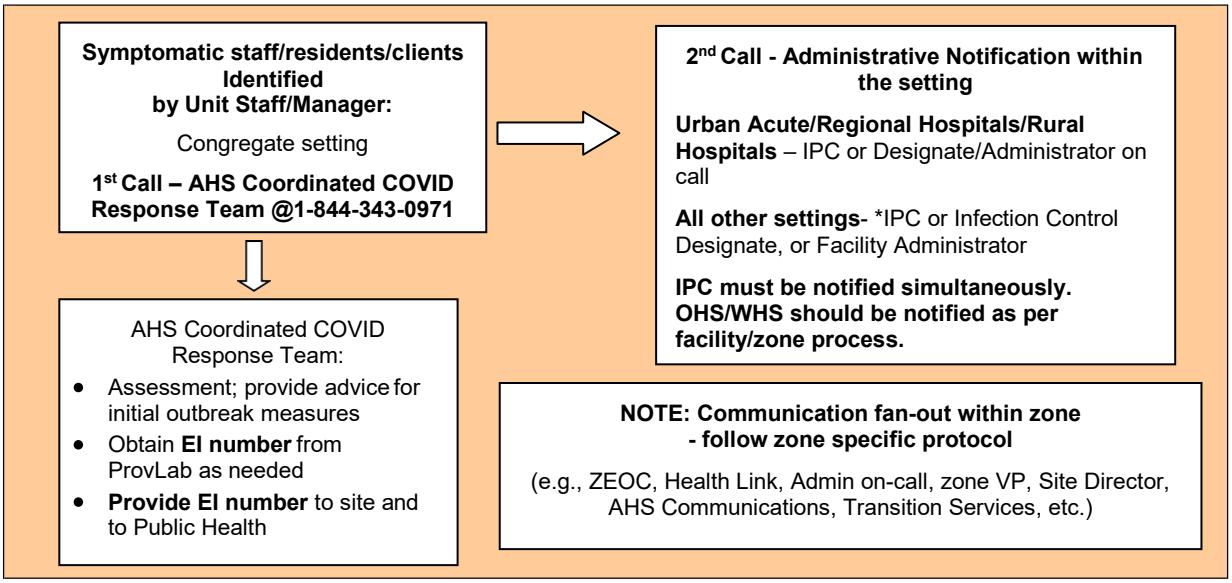
*By CMOH Order **23-2020**, staff must **immediately** tell their supervisor if they have worked in the last 14 days or are currently working at a site (including but not limited to the sites to which this order applies), where there is a **confirmed** COVID-19 outbreak. This disclosure is **mandatory** to protect the health and safety of the disclosing staff member, other staff as well as the health and safety of the residents/clients.*

1.5 Notification

In order to initiate a site investigation promptly, **immediately report a single suspected case of COVID-19 in residents/clients or staff to the AHS Coordinated COVID-19 Response (1-844-343-0971).** Prompt reporting permits early identification and interventions to interrupt transmission of COVID-19 as soon as possible, reducing morbidity and mortality. Initial outbreak control measures, staff restrictions, facilitation of testing and Personal Protective Equipment recommendations will be provided.

Follow internal protocols for site notification about staff or residents/clients that are being tested (see Table 2) e.g. to your IPC/ICD (where available) and follow Public Health instructions for collecting and reporting data once a confirmed outbreak is identified at your site.

Table 2: Outbreak Notification Algorithm for sites that have IPC/ICD*



1.6 Infection Prevention and Control Measures

While waiting for test results, implement full **contact and droplet precautions** in addition to routine IPC measures including consistent hand hygiene, respiratory hygiene, appropriate personal protective equipment (PPE) and isolation of symptomatic staff or residents/clients, as possible. AHS has a continuous masking guideline, in addition to use of personal protective equipment (PPE) as part of droplet and contact precautions. *Where there is evidence of ongoing transmission (two or more lab confirmed cases of COVID-19), continuous use of surgical/procedure mask and eye protection (e.g. goggles, visor, face shield) is recommended for staff providing direct face-to-face care of residents/clients or working in resident care areas.*

Additional precautions are necessary (see **Table 3**) if performing aerosol-generating medical procedures (AGMP). If staff/resident/client tests positive, maintain full IPC precautions until the resident/client is released from isolation.

- **PPE** - wear appropriate PPE as per Interim IPC recommendations COVID-19 for staff providing care to all isolated residents/clients (symptomatic or asymptomatic) **Donning and Doffing PPE**.
- **Hand hygiene** is the most important measure in preventing spread of infections. Practice consistent hand hygiene and respiratory hygiene.

- Place Visitor poster at the entrance of the facility/unit and screen any essential visitors prior to entering the facility.
  - Please note additional considerations for essential visitors as per **CMOH Order 14-2020**
- Place posters regarding physical distancing, hand hygiene (hand washing and hand sanitizer use) and limiting the spread of infection in areas where they are likely to be seen.
- Place Visitor poster and signage and inside the symptomatic resident's/client's room, near the door, alerting staff/visitors that the resident/client is symptomatic and precautions are required.
  - Place symptomatic residents/clients in single rooms if possible. If a single room is not available, residents/clients with infection due to the same micro-organism may be cohorted following consultation with IPC/Public Health. Maintain at least two (2) metres of physical separation between bed/stretcher spaces and any permitted designated essential visitor.

Note: Consult with IPC/ICD/Public Health as appropriate for assistance with IPC issues. All COVID-19 concerns or outbreak concerns in continuing care for all settings are being addressed through the central intake email continuingcare@albertahealthservices.ca. For other questions, including zone contacts, refer to the Continuing Care FAQ document.

Visitors: Long term care, supportive living and congregate settings have implemented a "No Visitor Policy**"** with special considerations for essential visitors* as per **CMOH Order 14-2020**. See Visitor poster; Visiting residents and patients during a pandemic.

All visits must be booked in advance. Updated visitor guidance is available here.

*Essential Visitor: designated by resident/client or guardian (or other alternate decision maker); may be a family member, friend or paid caregiver over 18 years of age.
Essential visitors must comply with all requirements:

- pre-arrange visits with facility manager, and be expected by site administration or charge nurse
- sign in and out of all visits and complete a standard Screening Questionnaire to assess health risk
- wear a mask continuously throughout their time in the facility and shall be instructed how to put on and take off the mask and any other PPE required by the staff/operator
- be escorted by site staff to resident's/client's room and remain in that room for the duration of the visit, other than when assisting with required quality of life care or care activities (e.g., meal time) or supporting an outdoor visit
- perform hand hygiene on entry and exit from rooms, when leaving and returning to the facility and as directed
- visitation with other residents is not permitted.

- **Self-Isolation**
  - Any individual (resident/client, staff or designated essential visitor) who has had direct contact with a person with confirmed COVID-19 without wearing recommended PPE is required to self-isolate as per the Order of the CMOH.
  - Any individual (resident/client, staff or visitor) who is experiencing symptoms of COVID-19 is required to isolate as per the Order of the CMOH.
- **Admissions/transfers**

  If the site is **under investigation** for COVID-19 due to symptomatic residents/clients only **(i.e., no staff)** having symptoms**,** consult with the AHS Zone MOH/designate before accepting new admissions into the site.
  - Having only symptomatic staff (i.e., no residents/clients) should not restrict admissions to the site.
    - Symptomatic staff should not work at the site until their isolation period is complete.

  Stop admissions and/or transfers into the site if a COVID-19 outbreak is confirmed, unless at the explicit direction of the AHS Zone MOH.

Sites/floors/wings experiencing a COVID-19 outbreak must implement additional IPC precautions to the extent that resources are available (e.g., private rooms with washroom facilities, physical layout of care units, housekeeping procedures and staffing patterns)

Table 3: COVID-19 - Infection Prevention and Control Practices and Additional Precautions

Interim IPC recommendations COVID-19. More detailed IPC recommendations are available on the AHS website (search: 'infection control') for the most current recommendation

Implement Contact and Droplet Precautions in addition to Routine practices when caring for symptomatic residents/clients to control the spread of respiratory viruses: AHS has a continuous masking guideline, in addition to use of personal protective equipment (PPE) as part of droplet and contact precautions. Where there is evidence of ongoing transmission (two or more lab confirmed cases of COVID-19), continuous use of surgical/procedure mask and eye protection (e.g. goggles, visor, face shield) is recommended for staff providing direct face-to-face care of residents/clients

- Resident/Client Placement and Signage
  - Single-room preferred
  - maintain a distance of two (2) metres between residents/clients sharing a room

Personal Protective Equipment (PPE): Gowns, Gloves and Facial Protection

- Wear new PPE to enter patient room or bedspace. Healthcare workers are to wear contact and droplet PPE even if the patient is wearing a mask.
- Do not wear PPE outside a patient room or bedspace unless transporting contaminated items.
- Remove soiled PPE as soon as possible.
- Gloves are single-use. Use only once, then dispose of immediately after use.
- Change gloves between care activities for the same patient (e.g., when moving from a contaminated body site to a clean body site). Sterile gloves are for sterile procedures.
- For more detailed information on glove use see Glove Use and Selection: IPC Best Practice Guidelines or Proper Glove Use as part of Personal Protective Equipment.
- Prescription glasses do not meet Workplace Health and Safety regulations for eye protection.
- New guidance released for continuous masking. Proper wearing of masks includes:
  - ensuring a snug fit over the nose and under the chin;
  - discard mask when it becomes wet/moist or soiled and replace with a new one.
- Refer to the AHS Donning and Doffing PPE posters for details on careful removal and disposal of PPE. Do not reuse or disinfect single-use PPE. Reusable PPE must be cleaned before reuse (launder gowns, disinfect eye protection).

Effective and appropriate use of PPE keeps **staff uniforms and clothing** clean. Staff may change before leaving healthcare facility, and take soiled clothing home in a bag. Soiled uniforms/clothing do not need any special handling in the laundry. Refer to Staff Tips: COVID-19 Personal Clothing and Cleaning Surfaces. Further information and resources on PPE can be found here.

- Hand Hygiene (4 moments from AHS Hand Hygiene Policy)
  - Before contact with a resident/client or resident's/client's environment including but not limited to: putting on (donning) personal protective equipment; before entering a resident's/client's room; and, before providing resident/client care.
  - Before a clean or aseptic procedure including but not limited to: wound care; handling intravenous devices; handling food; or, preparing medications.
  - After exposure (or risk of exposure) to blood and/or body fluids including but not limited to: when hands are visibly soiled; following removal of gloves.
  - After contact with a resident/client or resident's/client's environment including but not limited to: removing (doffing) personal protective equipment; leaving a resident's/client's environment and after handling resident/client care equipment.
- Resident/Client Care Equipment
  - Dedicate to this resident/client or clean and disinfect after use
- Resident/Client Transport
  - Transport for essential purposes only
  - Residents/clients wear mask during transport and hands should be cleaned
  - Notify receiving department

Refer to the AHS Donning and Doffing PPE posters for details on careful removal and disposal of PPE. Do not reuse or disinfect single-use PPE. Reusable PPE must be cleaned before reuse (launder gowns, disinfect eye protection).

1.7 Specimen Collection

- Contact the **AHS Coordinated COVID-19 Response line at 1-844-343-0971** to report newly symptomatic staff or residents/clients; they will provide instructions on specimen collection and an EI number for the lab requisition (see Attachment 1). Sites that have already collected specimens should not send these to the laboratory until they have contacted the AHS Coordinated COVID-19 Response line at 1-844-343-0971 and obtained an EI number to ensure coordination of testing.

Testing of Previous Cases

- Residents who have previously tested positive for COVID-19, have recovered, and who then have new symptoms should only be tested if it is more than 30 days after their previous positive result or if, in the opinion of the local MOH, a case-specific assessment warrants re-testing.

1.8 Additional Outbreak Control Strategies

- Authorize and deploy additional resources to manage the outbreak as needed.
- Where possible, restrict symptomatic residents/clients to their room (with dedicated bathroom if possible, with meal tray service in room, etc.); if not possible, restrict to own unit/wing.
    - For residents/clients requiring **urgent medical care**, ensure that appropriate IPC precautions are maintained during transport and at the receiving site, AND ensure that the transport team and receiving site are advised of the possibility of COVID-19.
    - Residents/clients who are not required to isolate must remain on the facility's property (except in the case of necessity) if there is a confirmed outbreak at the site.
- Group dining may continue for non-isolated residents.
- Subject to requirements set out in CMOH **Order 23-2020**.
- Scheduled resident group recreational/special events must be cancelled/postponed if a site is in a **confirmed outbreak**.
    - At the discretion of the operator, a site under investigation may have to cancel activities based on the extent of affected residents/clients, interruption of daily operations, type of symptoms, etc.
- Recreational activities for non-isolated residents are permitted and encouraged, subject to requirements set out in CMOH **Order 23-2020**.
- Apply site-level restrictions and other control measures as recommended by Public Health.

1.9 Environmental and Equipment Cleaning (routine practice, and also during outbreaks)

The virus that causes COVID-19 has the potential to survive in the environment for up to several days. A person who has contact with an inanimate object such as contaminated surfaces and objects is at risk of infection. Cleaning, particularly of frequently touched surfaces, can kill the virus, making it no longer possible to infect people. AHS recommendations for cleaning can be found here Environmental Cleaning in Public Health Facilities.

- Operators of facilities may develop an approach to environmental cleaning and disinfection that includes the role of their staff, service providers (e.g. home care) and visitors in carrying out the following: staff handling soiled laundry should wear gloves. Gowns should also be worn if there is a risk of contaminating clothing.
- Enhance general environmental cleaning using a disinfectant with a Drug Identification Number (DIN) and virucidal claim. The thoroughness of cleaning is more important than the choice of disinfectant used.
- Disinfection and cleaning is a two-step process. Use of disinfectant after cleaning is best and is most effective to reduce the spread of infection.
    - Surfaces must first be cleaned prior to disinfection. If the surface disinfectant product used has cleaning properties (detergent/disinfectant), it may be used for both steps. Follow manufacturer's directions for use.
- *Clean and disinfect:*
    - *Any health care equipment (e.g. wheelchairs, walkers, lifts) according to manufacturer's instructions.*
    - *Any shared resident health care equipment (e.g. commodes, blood pressure cuffs, thermometers) before use in the care of another resident/client.*
    - *All staff equipment (e.g. computer carts and/or screens, medication carts, charting desks or tables, telephones, touch screens, chair arms) at least daily or when visibly soiled.*

- Residents/clients that do not have staff or designated essential visitors entering their room on a regular basis **do not** require an increase to their regular scheduled weekly cleaning.
- *Residents/clients that have staff and/or designated essential visitors entering their room on a regular basis require:*
    - ***Low touch** (e.g. shelves, benches, windowsills, message or white boards**) areas cleaning **daily.***
    - ***High touch** (e.g., doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote) area cleaning **three times per day.***
- Be sure to use the appropriate precautions when using chemicals for cleaning and disinfecting. Consult the products Material Safety Data Sheets. Cleaning should be performed using the proper personal protective equipment (PPE). The correct donning and doffing of PPE should be followed. Donning and Doffing PPE.
- Equipment should be cleaned and disinfected only with a product listed in and following the procedures outlined in the manufacturer's directions for that equipment.
- Upholstered furniture and rugs or carpets should be cleaned and disinfected when contaminated with emesis or stool, but may be difficult to clean and disinfect completely. Consult manufacturer's recommendations for cleaning and disinfection of these surfaces. If appropriate manufacturer's recommendations are not available, consult Public Health. Consider discarding items that cannot be appropriately cleaned/disinfected, when possible/appropriate.
- Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak as per facility protocols.

1.10 Communication

Operators will notify all residents/clients, staff and families according to the requirements in the CMOH **Order 23-2020**.

1.11 Monitoring Outbreak Status

- Once a confirmed COVID Outbreak has been declared by Public Health, communicate and track outbreak status by completing and submitting daily case listings **by 1000h** to Public Health through the secure, online entry portal on the Alberta Health Services external website (*link will be sent to site directly at start of outbreak*) for the purpose of Public Health outbreak management.
- Each setting is also responsible to maintain their own visitor log and tracking of all entry and exit in case this information is needed in future.

1.12 Declaring Outbreak Over

Public Health will determine when to declare the confirmed COVID-19 outbreak over and lift any site restrictions. Generally, a COVID-19 outbreak can be declared over two incubation periods after the last reported case in a resident/client. Following a confirmed outbreak, key program leads need to review and evaluate their role in the outbreak management and revise internal protocols for improvement where necessary. Any member of the Outbreak Management Team (OMT) can request a debrief session to address outbreak management issues.

Attachment 1: Public Health Laboratories (formerly ProvLab) Respiratory Specimen Collection Guidelines

Check ProvLab Bulletins for most current information on specimen collection, testing and interpretation of lab Results http:\\provlab.ab.ca or http://www.albertahealthservices.ca/3290.asp

ProvLab Bulletin (May 11, 2011) - New Laboratory Policy, Acceptance of Laboratory Samples and Test Requests.

ProvLab Bulletin (August 22, 2011) – Reminder Laboratory Policy, Acceptance of Laboratory Samples and Test Requests.

The Requisition must be completed to include:

- Resident's/Client's full name (first and last names)
- Resident's/Client's Personal Health Number (PHN) or unique numerical assigned equivalent
- Resident's/Client's demographics including: date of birth (DOB), gender, address, phone number
- Physician name (full name), address/location
- Test orders clearly indicated, including body site and sample type, date and time of collection
- Clinical history and other clinical information
- Facility/site name, and if applicable, unit
- EI# (assigned by the Public Health lab and provided to Public Health Lead investigator) – for both symptomatic and for asymptomatic individuals.
- **Requisition must indicate clearly** whether the person being tested is **asymptomatic or symptomatic by checking off the appropriate box** in that section and complete the symptom list for symptomatic persons.
- Fax number of outbreak facility/unit or ICP/ICD office

Note: EI# must be clearly recorded on the requisition.

Specimen Transport:

- Settings must collect specimens as directed by the AHS COVID-19 Response line/Public Health and arrange for delivery to the laboratory.
- Follow current Public Health Laboratories standards for transporting specimens at http://www.provlab.ab.ca/guide-to-services.pdf.

SPECIMEN COLLECTION FOR DETECTION OF RESPIRATORY INFECTIONS

General Information:

- Acceptable specimen types for COVID-19 testing include NP swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW). Nasopharyngeal (NP) and throat swabs are recommended over nasal swabs for COVID-19 testing. The ESwab collection kit is to be used for **throat swabs**.
- Use contact and droplet precautions to collect specimens as directed by Public Health
- Results for COVID-19 are *usually* available within 48-96 hrs. or sooner

If the specimens are for outbreak diagnosis, ensure specimen is transported to the lab ASAP. The EI# must be included on each requisition so that specimens receive appropriate testing. Rural facilities must transport lab specimens to the Public Health Laboratories as directed by the AHS COVID-19 Response line/Public Health or by the fastest means possible.

Congregate Living Settings - Recommendations for Cohorting Clients during COVID-19 Outbreak

Introduction

Client cohorting is the assignment, relocation or movement of two or more clients exposed to, or infected with, the same laboratory-confirmed pathogen to the same room, treatment space or clinical area. Cohorting is a strategy which can be used when requirements for private rooms exceed capacity.

Cohorting contributes to the control of outbreaks by segregating known infectious clients and should be considered as part of a thorough outbreak management response and surge plan.

Cohorting should occur after all other methods of outbreak management have been implemented and should occur in consultation with clients, families, care teams and the outbreak management team. All efforts to ensure clients are kept in a familiar environment with their belongings and comfort items should be considered.

Clients may remain in their semi-private space while under investigation for COVID-19, with contact droplet precautions in use by all individuals entering that space (otherwise known as "isolation without walls") while maintaining 2 metres of space between bed spaces. Once a client is deemed to be positive for COVID-19, all efforts shall be made to move the client to a private room.

An infection prevention and control (IPC) professional or the Medical Officer of Health (MOH)/designate shall be included when a decision to cohort is required.

Planning strategy

Comprehensive pandemic planning and emergency preparedness needs to consider the potential requirement to cohort clients during an outbreak management response. Assignment, relocation and movement of clients from their familiar surroundings to a new space has the potential to be traumatic to clients (relocation stress syndrome). Families and clients must be part of the planning process to create awareness and understanding of the need to reduce the risk of transmission while supporting client care needs. Planning during a pandemic response, where visitor restrictions are in place, should consider other forms of communication with families such as virtual or teleconference.

Planning will also need to take into account the client population, facility size, facility layout and staff compliment. For example, sites of 25 beds or less and/or sites with only semiprivate rooms may not have the space or staffing allocation to relocate clients regardless of how many clients are requiring contact and droplet precautions. Additional consideration should be given to the potential number of affected residents, bed vacancy, mix of bed spaces, surge capacity and staff training related to outbreak management and client care. Strategies to cohort staff (assign staff to specific areas or clients; ensure staff provide care to asymptomatic clients prior to symptomatic) may also need to be considered.

Vacancy management

During a pandemic response, vacancy may occur within a facility. In the event that vacancy occurs, assignment, relocation and movement of clients should be considered to reduce the risk of transmission and exposure. For example if the bed mix includes both private and semi-private spaces,

clients who are at higher risk of transmission to others (i.e. currently in a semi-private where one client is on contact and droplet precautions) may benefit from moving to a vacant room. Clients who have aerosol generating medical procedures (AGMP) as part of their care needs may also require a private room.

The utilization of bedside isolation (or isolation without walls) in semiprivate rooms may be disconcerting for clients in the other bed space. Maximizing the use of private bed spaces and consideration of temporary moves to relocate clients that are suspected, probable or confirmed together in the same unit or area may reduce the risk of transmission to others. In small sites, or depending on the layout of the facility, there may be no benefit from or ability to cohort clients. Utilization of clinical decision making, evidence-informed practice and collaboration between care teams, clients, families and the outbreak management team (including IPC, the MOH or designate) will be an essential part of determining how to fully utilize any vacancy at your site.

Additional considerations

Accommodation fees for semiprivate and private rooms in designated living options differ. Additional costs may deter clients from choosing private rooms where that choice exists. Most facilities also have extensive waitlists for private rooms. As relocation into private rooms may need to be temporary, it is essential to provide clear written information to clients and families to ensure that there is understanding that COVID related costs will be covered. Additional accommodation fee costs, related specifically to cohorting, should be tracked by the operator as these should be covered as part of the reimbursement of COVID related expenses from the Government of Alberta.

Recommendations

Information on client assignment, relocation or movement for communicable diseases is found in the AHS IPC Continuing Care Resource Manual.

Cohorting decisions must involve key administrative and clinical leaders in consultation with Infection Prevention & Control (IPC) and / or the Medical Officer of Health (MOH)/designate.

When cohorting is used, **bedside isolation** or **isolation without walls** is required. This means treating each bed space as a private room.

The following recommendations can be used in the management of isolation clients in AHS continuing care facilities:

- **Clients with more than one transmissible disease/organism are not candidates for cohorting.**
- Adhere to IPC point-of-care risk assessment, hand hygiene, appropriate use of personal protective equipment (PPE), and appropriate environmental cleaning guidelines.
- Separate client beds by a minimum of 2 metres.
- Create a visual barrier to define the isolation space(s). A privacy curtain or a portable wipeable screen may be used. Isolated spaces must be treated as though they are a separate room.

- Place dedicated isolation cart at entrance of room/each isolation space. Place the linen hamper and garbage receptacle in close proximity.
- Dedicate client care items and equipment to each isolated client if possible. Otherwise, clean and disinfect items before use with any other client. Shared items that cannot be cleaned/disinfected should be discarded.
- Request that staff follow organizational protocols for isolation/terminal cleaning of the isolation area once a client has been transferred to a single room or is discharged.
- **When** cohorting, consideration should also be given to:
    - underlying patient conditions (e.g., immune-compromised, dementia);
    - vaccination status, especially for influenza with respect to co-infection;
    - co-infection with other diseases (e.g. influenza).
- Outbreak measures, such as cohorting, physical distancing in all areas of the facility, isolation of symptomatic residents, outbreak signage posted, enhanced cleaning, strict hand hygiene, restriction of visitors, and cancellation of group activities, apply to the entire facility.

Additional COVID-19 cohorting measures:

- Roommates of COVID-19 positive cases should be put on Contact and Droplet precautions for 14 days from time of last exposure to a positive case(s).
- Attempt to move COVID-19 confirmed clients to a private room or cohort with other COVID-19 confirmed clients in a multi-bed room. Note that the roommate is still considered a close contact and would require isolation for 14 days. Consider risk of exposure and transmission to others when relocating clients to other rooms/areas.
- **Asymptomatic** clients should be cared for before those on Contact and Droplet precautions.
- Attempt to cohort staff: have specific staff only care for those on contact and droplet precautions. Refer to recommendations on staff cohorting
- For guidance on PPE use, including when to change/remove PPE see Table 1.
- Refer to the Guidelines for Outbreak Management in Congregate Living Sites COVID-19 for additional information.

Please consult with IPC/MOH or designate for your site if you have questions on these recommendations, note increased numbers of symptomatic clients, or require assistance on assignment, relocation or movement of clients with suspect or confirmed COVID-19.

Table 1 – Considerations for PPE utilization when cohorting one or more clients

Proportion of Cases	PPE Use	Recommended Measures	Conservation Strategy
One client with symptoms (as per Resident Daily Screening) or confirmed with COVID-19	Staff should follow continuous masking guidelines in all client care areas and during client care. Clients with symptoms (as per daily resident screening) or confirmed COVID-19 require Contact and Droplet precautions.	Remove gloves, gown, eye protection and mask after caring for clients on Contact and Droplet precautions and don a new mask. All PPE, except for continuous masks, should be removed before entering non-client care areas including charting area where physical distancing cannot be maintained. Implement all conservation strategies.	May wear same mask between asymptomatic clients.
2 or more cases AND Less than 20% of clients have symptoms (as per Resident Daily Screening) or confirmed COVID-19. **For small sites, less than 50 beds, consult IPC or MOH/or designate for guidance on when to cohort and when to enact PPE conservation measures.	Staff should follow continuous masking guidelines in all client care areas and during client care. In consultation with IPC/MOH or designate, consider continuous eye protection (goggles, face shield) for direct client care and when in client care areas. Clients with symptoms (as per Resident Daily Screening) or confirmed COVID-19 require Contact and Droplet precautions.	Remove gloves, gown, and eye protection and mask after caring for clients on contact and droplet precautions and don a new mask when finished the isolated clients care. Do not wear PPE used in rooms of clients on droplet & contact precautions into non-client care areas including charting area. Implement all conservation strategies.	Do not wear gowns, gloves or eye protection for asymptomatic clients unless advised by the IPC/MOH or designate. If clients in same room (multi-bedded room) are suspected or confirmed COVID-19: Gown, mask and eye protection can be worn from client to client in multi-bedded rooms. Gloves must be changed and hand hygiene performed between clients. If PPE is soiled with blood or body fluids it should be changed between clients.
Proportion of clients with symptoms (as per	Staff should follow continuous masking	If clients in same room (multi-bedded room) are	Do not wear gowns, gloves or eye protection

Proportion of Cases	PPE Use	Recommended Measures	Conservation Strategy
Resident Daily Screening) or confirmed clients with COVID-19 is greater than 20% (For small sites, less than 50 beds, consult IPC or MOH/or designate for guidance on cohorting and when to enact PPE conservation measures).	guidelines in all client care areas and during client care. In consultation with IPC/MOH or designate, consider continuous eye protection (goggles, face shield) for direct client care and when in client care areas. Clients with symptoms (as per daily resident screening) or confirmed COVID-19 require Contact and Droplet precautions. Roommates of COVID-19 positive cases should be put on Contact and Droplet precautions for 14 days from time of last exposure to a positive case(s).	suspected or confirmed COVID-19: Gown, mask and eye protection are to be worn from client to client in multi-bedded rooms. Gloves must be changed and hand hygiene performed between clients. Do not wear PPE used in rooms of clients on droplet & contact precautions in non-client care areas, including charting area. Implement all conservation strategies.	for asymptomatic clients unless advised by the IPC/MOH or designate. Continuous use of gowns, masks and eye protection can be worn between clients on Contact and Droplet precautions. Change gloves and perform hand hygiene between all clients, and prior to entering common spaces. Discard PPE when visibly soiled, wet or contaminated with blood or body fluids. Remove PPE at breaks. Don a new masks and eye protection (if applicable) after breaks. Dispose PPE at end of shift. Gloves must be changed and hand hygiene performed between all residents.

Asymptomatic – residents who do not present with any symptoms of COVID-19, or have such mild symptoms they are difficult to detect.

Congregate Living Settings
Recommendations for Staff Cohorting during COVID-19

Applicability

This document is applicable to congregate living settings providers inclusive of long term care and designated supportive living, lodges, group homes, personal care homes, and other congregate living settings.

Operator applies to any congregate living setting provider inclusive of all of the above settings.

This document provides broad evidence-based principles related to infection prevention and control (IPC) and public health (PH). Implementation of these principles will need to occur utilizing clinical judgement and evidence-informed practice considering the multiple implications that size, setting, staff compliment and client population may have on decision making.

Introduction

Staff cohorting is the assignment of staff to clients or groups of clients based on client exposure to, or infection with, the same laboratory-confirmed pathogen. Cohorting is a strategy which can be used to reduce risk of transmission.

Staff who are following hand hygiene guidelines, using appropriate PPE and applying it correctly while caring for clients with symptoms of COVID-19, are not considered contacts and may safely enter public spaces within the facility or other rooms. Staff are also required to follow continuous masking guidance.

Any individual (client, staff or designated essential visitor) who has had direct contact with a person who is confirmed for COVID-19, without wearing recommended PPE (i.e., before they are aware that the person is confirmed COVID-19), is required to self-isolate as per the Chief Medical Officer of Health (CMOH) direction.

To protect the most vulnerable Albertans, designated supportive living (DSL) and long term care (LTC) staff are limited to working within one single healthcare facility. This will help to prevent the spread of illness between facilities. This order from the CMOH is inclusive of all staff at the facility (e.g. healthcare workers, food service workers, housekeeping, administrative, home care staff, etc.). The intent of the CMOH order is to limit the risk of transmitting COVID-19 to our most vulnerable by reducing the number of different people that interact with residents. Facility operators, in collaboration with physicians and nurse practitioners, must determine the model of medical care that is appropriate for their clients that minimizes the number of physicians or nurse practitioners physically attending clients in that facility. Physicians and nurse practitioners should provide onsite, in-person care in only one facility, as defined by the order, to the greatest extent possible.

Planning strategy

Comprehensive pandemic planning and emergency preparedness needs to consider the potential requirement to cohort staff during an outbreak management response. Assignment, relocation and movement of staff should occur in the context of trying to ensure that the risk of cross-contamination/transmission to both staff and clients is reduced. Designated leaders may want to include families and clients as part of the planning process to create awareness and understanding of

the need to reduce the risk of transmission while supporting client care needs. Consideration should be made to ensure assignment of staff that are familiar with clients and their care needs. Planning during a pandemic response, where visitor restrictions are in place and services are reduced, should also consider the additional emotional and social needs of clients and how these will be met with the existing staff model.

Planning will also need to take into account the client population, facility size, facility layout and staff compliment. For example, sites of 25 beds or less may not have the staffing allocation to reassign staff regardless of how many clients are requiring contact and droplet precautions. For larger sites, the utilization of float staff (assigned to provide additional support to multiple care areas or units) may need to be restricted to ensure staff are not moving between symptomatic and asymptomatic clients. Additional consideration should be given to the potential need for increased educational support for staff during a pandemic. Point in time information will need to be available to ensure staff have the resources and educational materials available for them to make accurate clinical decisions and adhere to infection prevention and control practices. For example, having buddies assigned to assist with donning and doffing practices or having team huddles to discuss any changes in practice.

Vacancy management

During a pandemic response, staff vacancy may occur within a facility. In the event that vacancy occurs, assignment, relocation and movement of staff should be considered to reduce the risk of transmission and exposure to clients. Reduced staffing can increase the risk of transmission as staff are rushed in completing care tasks. Discussions with designated leaders and the outbreak management team will create awareness of staffing issues so that they can be addressed. Many organizations have put forward lists of staffing availability and professional organizations are working to streamline access to registration.

Additional considerations

Ensure that staff are utilizing a systematic approach to provide care for asymptomatic clients first, or separately from, care for symptomatic clients. In small sites, or depending on the layout of the facility, there may be no benefit from or ability to cohort staff. Auxiliary hospitals that are attached to acute care facilities may share staff. Utilization of clinical decision making, evidence-informed practice and collaboration between care teams, clients, families and the outbreak management team (including IPC, the MOH or designate) will be an essential part of determining how to fully utilize staff at the site.

Staff health

Staff must complete fitness for work screening. Staff must report symptoms immediately and must not attend to work if they have symptoms. In addition, staff must leave work immediately if they are experiencing symptoms. Team huddles at routine intervals throughout the shift will create an opportunity for staff to re-check for symptoms (as applicable) and will prompt staff to report any symptoms. In order to ensure staff are returning to work in a timely manner the return to work guide can assist both staff and operators to determine when staff are fit to return.

Recommendations

Congregate living settings operators must advise staff that they are required to conduct twice daily self-checks (like all Albertans) for signs of COVID-19, for their own health as well as prior to coming to work.

- Any staff member that determines they are symptomatic at any time shall notify their supervisor and/or the facility operator and remain off work for 10 days or until symptoms resolve, whichever is longer, or as per direction of the Chief Medical Officer of Health, or where the staff has had a negative swab and all symptoms have resolved. If symptoms develop while the staff member is on shift, they must notify their supervisor and immediately leave the facility and self-isolate. Refer to Return to Work Guide for additional information.
- Any staff developing symptoms while at work must not remove their mask and must be sent home immediately. Staff must inform all their managers and leads that they report to of their new onset of symptoms.
- Site administrators must exclude symptomatic staff from working.

Congregate living setting operators must ensure that all staff working in DSL and/or LTC are assigned to only one DSL or LTC facility and restricted from working at any other DSL or LTC facility.

- Staff that work at multiple sites must inform their employers immediately and arrange to be assigned to one single site.

Congregate living setting operators must assign staff (cohort), to the greatest extent possible, to either:

- Exclusively provide care/service for clients that are asymptomatic (no illness or symptoms of illness); or
- Exclusively provide care/service for clients who are symptomatic (have suspected or confirmed COVID-19).

When cohorting of staff is not possible:

- Minimize movement of staff between clients who are asymptomatic and those who are symptomatic; and
- Have staff complete work with asymptomatic clients first before moving to those clients who are symptomatic.

The following recommendations can be used in the management of cohorting staff in congregate living settings:

- Staff with any symptoms are not to attend to work and must leave work immediately if they are experiencing any symptoms.
- Adhere to IPC point-of-care risk assessment, hand hygiene, appropriate use of personal protective equipment (PPE), and appropriate environmental cleaning guidelines.
- For guidance on when to change/remove PPE and perform hand hygiene see Table 1.
- Follow IPC Healthcare Attire recommendations.
- Follow social distancing practices and consider modifications to work spaces and common areas (i.e. lunch rooms and locker rooms) to provide a safe working distance (2 metres/6 feet) for staff.
- Attempt to cohort clients and have specific staff care for those clients on contact and droplet precautions. Refer to recommendations on client cohorting.
- Refer to the Guidelines for Outbreak Management in Congregate Living Sites COVID-19 for additional information.

Please consult with IPC/MOH or designate for your site if you have questions on these guidelines, note increased numbers of symptomatic staff, or require assistance on assignment, relocation or movement of staff with suspect or confirmed COVID-19.

Table 1 – Considerations for PPE utilization when cohorting one or more clients

Proportion of Cases	PPE Use	Recommended Measures	Conservation Strategy
One client with symptoms (as per Resident Daily Screening) or confirmed with COVID-19	Staff should follow continuous masking guidelines in all client care areas and during client care. Clients with symptoms (as per daily resident screening) or confirmed COVID-19 require Contact and Droplet precautions.	Remove gloves, gown, eye protection and mask after caring for clients on Contact and Droplet precautions and don a new mask. All PPE, except for continuous masks, should be removed before entering non-client care areas including charting area where physical distancing cannot be maintained. Implement all conservation strategies.	May wear same mask between asymptomatic clients.
2 or more cases AND Less than 20% of clients have symptoms (as per Resident Daily Screening) or confirmed COVID-19. **For small sites, less than 50 beds, consult IPC or MOH/or designate for guidance on when to cohort and when to enact PPE conservation measures.	Staff should follow continuous masking guidelines in all client care areas and during client care. In consultation with IPC/MOH or designate, consider continuous eye protection (goggles, face shield) for direct client care and when in client care areas. Clients with symptoms (as per Resident Daily Screening) or confirmed COVID-19 require Contact and Droplet precautions.	Remove gloves, gown, and eye protection and mask after caring for clients on contact and droplet precautions and don a new mask when finished the isolated clients care. Do not wear PPE used in rooms of clients on droplet & contact precautions into non-client care areas including charting area. Implement all conservation strategies.	Do not wear gowns, gloves or eye protection for asymptomatic clients unless advised by the IPC/MOH or designate. If clients in same room (multi-bedded room) are suspected or confirmed COVID-19: Gown, mask and eye protection can be worn from client to client in multi-bedded rooms. Gloves must be changed and hand hygiene performed between clients. If PPE is soiled with blood or body fluids it should be changed between clients.
Proportion of clients with symptoms (as per Resident Daily	Staff should follow continuous masking guidelines in all client	If clients in same room (multi-bedded room) are suspected or confirmed	Do not wear gowns, gloves or eye protection for asymptomatic clients

Proportion of Cases	PPE Use	Recommended Measures	Conservation Strategy
Screening) or confirmed clients with COVID-19 is greater than 20% (For small sites, less than 50 beds, consult IPC or MOH/or designate for guidance on cohorting and when to enact PPE conservation measures).	care areas and during client care. In consultation with IPC/MOH or designate, consider continuous eye protection (goggles, face shield) for direct client care and when in client care areas. Clients with symptoms (as per daily resident screening) or confirmed COVID-19 require Contact and Droplet precautions. Roommates of COVID-19 positive cases should be put on Contact and Droplet precautions for 14 days from time of last exposure to a positive case(s).	COVID-19: Gown, mask and eye protection are to be worn from client to client in multi-bedded rooms. Gloves must be changed and hand hygiene performed between clients. Do not wear PPE used in rooms of clients on droplet & contact precautions in non-client care areas, including charting area. Implement all conservation strategies.	unless advised by the IPC/MOH or designate. Continuous use of gowns, masks and eye protection can be worn between clients on Contact and Droplet precautions. Change gloves and perform hand hygiene between all clients, and prior to entering common spaces. Discard PPE when visibly soiled, wet or contaminated with blood or body fluids. Remove PPE at breaks. Don a new masks and eye protection (if applicable) after breaks. Dispose PPE at end of shift. Gloves must be changed and hand hygiene performed between all residents.

Asymptomatic – residents who do not present with any symptoms of COVID-19, or have such mild symptoms they are difficult to detect.

Medical Officer of Health Guidelines for Transfers, Discharges and Admissions During COVID-19 Pandemic

Principles/Approach:

- Creating capacity in the health care system requires, among other measures, that hospitalized patients positive for COVID-19 and still infectious, and asymptomatic patients not known to be positive, be discharged or transferred safely from acute care once they are medically stable.
- Acute Care sites typically obtain the necessary approvals/consents from attending physicians, patients/families/guardians and communicate with the receiving site regarding readiness to receive the patient. The receiving site must have adequate preparation time to review their isolation/PPE procedures, including staff training before accepting a COVID+ve patient.
    - In addition, AHS Zone Medical Officers of Health (MOH) or delegate should be consulted as part of the decision-making for discharge, transfer or admission, as determined by existing Zone/MOHs processes, and provincial transfer and discharge guidelines during COVID-19.
    - The MOH will not waive the need for consent if a patient/family does not consent.
    - MOHs have significant experience in carrying out an individualized risk assessment for patient discharge home or transfer to a continuing care facility, especially in the event of outbreaks at either the sending or receiving facility; they take into account numerous factors such as patient factors (including infectiousness), receiving site factors (including ability to isolate an infectious patient adequately to prevent further spread), outbreak status at the sending or receiving facility, capacity to provide care at the receiving facility, capacity concerns at the sending facility, and any other factor that has a bearing on the decision.
- Generally speaking, MOHs are concerned about transfer of a COVID-19 positive patient from acute care to a continuing care facility because of the risk of introducing COVID-19 to such a facility; the Zone MOH or delegate will assess the risk and advise whether the transfer should proceed or be deferred.
- Zones may have algorithms in place outlining the steps to be taken in discharging or transferring patients from acute care facilities, or for new admissions to community sites. These include consultation with Zone MOHs. Zone MOHs should work with the responsible groups to promote appropriate collaboration and coordination of the discharge/transfer/admission process.

Considerations:

1. Orders from the Chief Medical Officer of Health (CMOH Order 10-2020, and 12-2020) are applicable to LTC, and licensed supportive living (SL) (including group homes and lodges):

    Admissions to LTC and licensed SL (CMOH Order 12-2020):
    - All new admissions to a facility must be placed on contact/droplet isolation for 14 days from arrival to facility.
    - The operator of a facility should consult the AHS Zone MOH or delegate before accepting new admissions into the site if the site is under investigation for a COVID-19 outbreak.
    - The operator of a facility must stop admissions into the site if there is a confirmed COVID-19 outbreak, except as explicitly directed by the AHS Zone MOH.

Transfers to LTC and licensed SL (CMOH Order 10-2020 and CMOH Order 12-2020):

- Current residents that return to the facility from other settings may be placed on contact/droplet precautions for 14 days at the discretion of the operator. Further guidance about this is being developed by Seniors Health.
- The operator of a facility should consult with the AHS Zone MOH or delegate before accepting a transfer into the site once the site is under investigation for a COVID-19 outbreak.
- The operator must stop transfers into the site once there is a confirmed outbreak, unless at the explicit direction of the AHS Zone MOH.

CMOH Order 13-2020 is applicable to licensed residential treatment facilities:
Admissions and transfers to licensed residential treatment facilities (CMOH Order 13-2020):

- All new residents are required to wear a mask (surgical or procedural) for 14 days from the time they are admitted to the treatment facility.
- Current residents that return to the treatment facility from other settings may be required to wear a surgical/procedure mask for 14 days, at the discretion of the operator.
- The operator of a treatment facility should consult the AHS Zone MOH or delegate before accepting admissions and/or transfers into the site if the site is under investigation for a COVID-19 outbreak.
- The operator of a treatment facility must stop admissions and/or transfers into the site if there is a confirmed COVID-19 outbreak, unless at the explicit direction of the AHS Zone MOH.

AHS Zone Medical Officers of Health should use consistent decision-making methods in determining whether to permit an admission and/or transfer to a facility during any level of outbreak (under investigation or confirmed COVID-19) based on:

- number of residents/staff affected by outbreak, onset dates relative to reporting date, and distribution of cases throughout the site. If receiving facility has site-wide outbreak or wide-spread disease activity, and new cases are occurring, either in residents or staff, do not transfer.
- ability of site to cohort staff to affected unit; number of staff shared among units. If staffing level is not adequate, or staff cannot be cohorted to provide care only for isolated residents, do not transfer.
- Acute Care capacity – if transfer is necessary to create capacity, MOH should refer to appropriate zone decision-making body for resolution.
- (not included within CMOH Orders – AHS Zone MOH should document any concerns identified and decisions made regarding admissions/transfers/discharges)

2. Considerations for admission/transfer to a continuing care site (including hospice):
   - Does the patient have gastrointestinal symptoms not related to COVID-19 (e.g. norovirus)? If yes, consider deferring transfer until 48 hours after symptoms have resolved or 96 hours after the onset of symptoms, whichever occurs first.
   - Is the receiving site already on outbreak (any level of COVID-19 (under investigation or confirmed) or respiratory organism)? The MOH may support transfer of a COVID

positive patient back to a facility if that facility/unit is already on outbreak, only if the facility can isolate appropriately and provide care.

- Is the receiving site on outbreak with another organism than COVID-19 causing severe clinical outcomes (e.g. iGAS, verotoxigenic *E coli*)? Consider deferring transfer to that site until that outbreak is declared over.
- Transferring a COVID positive patient to a facility that is not on outbreak does not mean that facility is now on outbreak.
- Transfer or admission of an asymptomatic patient not known to have COVID-19 to a receiving facility with no outbreak should proceed, with droplet/contact solation for 14 days from arrival at the facility as a precaution (CMOH Order 12-2020).
- Transfer of an asymptomatic patient not known to have COVID-19 to a unit of a facility that is not on outbreak (but other units are on any level of outbreak) may be considered if residents of the unit have had no exposure to the unit under outbreak and staff on the unit have not been exposed and are cohorted only to that unit.
- Testing of patients/residents who are not known to have COVID-19 is recommended prior to admission/transfer. Guidance is under development for this.

3. Considerations for discharge of COViD-19 positive patient to home:
   - Is patient likely to be compliant with isolation at home? Consider discharging to secure facility until isolation is lifted by public health if compliance is a concern; consult with ZEOC regarding access to such facilities, if they exist, in the zone.
   - Is there an appropriate healthy person at home to provide care to the patient? Is that person an essential services worker (e.g. health care worker)?
     - Close contacts of confirmed and probable cases of COVID-19 shall by CMOH Order be in quarantine for 14 days from the last date of exposure to the case. [see Public health disease management guidelines - COVID-19]. Explore other options for care provision at home; the essential worker could seek an alternate living arrangement.
   - Is home environment suitable for isolation? Separate bedroom and separate bathroom are preferred but other arrangements are possible with adequate separation and frequent cleaning and disinfection. Review How to Care for a COVID-19 Patient at Home with patient.
   - Are there household members present at increased risk of severe COVID-19 infection (e.g. people over 65 years of age, and those with chronic medical conditions such as high blood pressure, heart disease, lung disease, cancer or diabetes)? Explore options to keep these individuals from having close contact with the patient.

Process:

If a discharge or transfer of a COVID-19 positive or COVID-19 exposed patient is to proceed, ensure the following are in place:

- Isolation
  - Patients who are COVD-19 positive and on isolation in hospital must continue their mandatory isolation in the home/receiving site in the community until isolation has been lifted by public health as applicable.
    - For discharge home:
      - Isolate for 10 days from onset of symptoms or until symptoms resolve, whichever is longer, after arrival at home. No testing of clearance is required. [see Alberta Public Health Disease Management Guideline – COVID-19]

    - If patient is a health care worker, isolate for 10 days from onset of symptoms or until symptoms resolve, whichever is longer; the health care worker should not go back to work in a health care setting for 14 days from the onset of symptoms, or until symptoms resolve, whichever is longer. [see Alberta Public Health Disease Management Guideline – COVID-19]
    - Public Health will follow up with discharged positive patients at home on day 10 or when symptoms resolve, whichever is longer, to lift isolation as appropriate.
  - For transfer to continuing care facility:
    - Isolate (droplet and contact precautions) for 14 days from onset of symptoms, or until symptoms resolve, whichever is longer. No testing of clearance is required. The longer period of isolation is required because of the severity of disease in the patient and the vulnerability of the residents in the facility, [see Alberta Public Health Disease Management Guideline – COVID-19]
    - Consider private room for isolation, if possible.
    - Public Health will follow up with discharged positive patients at day 14 or when symptoms resolve, whichever is longer, to lift isolation as appropriate.
- Asymptomatic patients being discharged or transferred from an acute care unit with a COVID-19 outbreak (not a COVID unit) should be quarantined at home for 10 days or in the continuing care facility for 14 days respectively as noted above.

- Influenza precautions
  - If influenza is present in the patient or receiving facility, all influenza-specific precautions must be in place in addition to COVID-19 precautions:
    - Patient completes antiviral treatment or has received first dose of antiviral prophylaxis prior to transfer which must continue for the requisite time.
    - Patient has received influenza vaccine (subject to vaccine availability)
    - Consider private room if patient is influenza positive and still infectious

- Instructions for discharge home/follow-up in community
  - Provide instructions on How to Care for a COVID-19 Patient at Home and general self-isolation instructions.
  - Ensure medical management in the community is in place (e.g. Home Care, PCN, Primary Care Provider, etc.)

- Transportation
  - Transportation must be arranged before discharge/transfer is finalized and be done safely, limiting exposure to others:
    - To home - Private vehicle with mask on patient – no public transportation, taxi, ride-sharing if possible.
      - If no private vehicle available, consider a referral to ZEOC or use other supports within the zone. They must travel directly home with no stops in between.
      - If shared transportation is absolutely necessary, the person must travel directly home with no stops and engage in social distancing of no less than 2 metres from another person using the same shared transportation; they shall also wear a mask that covers the mouth and nose when using shared transportation.
    - To facility – existing patient transport, with appropriate PPE on transport staff, mask on patient. Maintain isolation and droplet-contact precautions during transfer. Vehicle must be cleaned adequately before further use.

Shelter Guidance:

Preventing, Controlling and Managing COVID-19

May 29, 2020

Alberta Health Services

Table of Contents

1. INTRODUCTION

Operators, staff and volunteers in emergency shelters and temporary housing for Albertans facing family violence, or homelessness and precarious housing play a critical role in the cycle of prevention, control and management of COVID-19 outbreaks. Managing an outbreak starts with preventive measures, followed by preparing and implementing a plan, and finally, controlling and resolving an outbreak. The different points along this continuum require specific actions and interventions, which are detailed in this document.

This document will help operators, staff and volunteers to prepare and know what will happen during an outbreak. It was developed by Alberta Health Services (AHS) in conjunction with Alberta Health (AH) and Community and Social Services (CSS) to ensure consideration of operational realities on the ground. Basic information and guidelines are included, as well as quick reference documents, like a pandemic checklist for shelters and temporary housing sites, website hyperlinks to information that changes frequently, and Frequently Asked Questions (FAQs) (Appendices 2, 3, and 4). While this document addresses many topics, shelter operators should proactively seek out and frequently check the Alberta Health and Alberta Health Services websites, as they provide the most current information on COVID-19.

Being prepared and setting clear actions with a plan in place will position shelters to respond effectively for the prevention, control and management of a COVID-19 outbreak. This is the best guidance that can be offered at this time and we will continue to work with partners to assess the situation going forward.

Intended audience

This document is intended for operators, staff and volunteers in emergency shelters and short-term and long-term transitional beds/units for Albertans facing family violence or homelessness and precarious housing. It may also be helpful for other social agencies where service providers may be in close contact with clients or residents who may be at greater risk for serious illness from COVID-19, such as those who are older and have pre-existing health conditions.

Each shelter in Alberta is unique and these guidelines are provided to help each site come up with their own plan to prepare and respond to the COVID-19 pandemic. The prevention and preparedness, screening, isolation, personal protective equipment (PPE) and reporting elements of this guide are applicable to all shelter settings and are critical to ensure the control the spread of COVID-19.

For ease, these settings will be referred to simply as ‘shelters’; residents, clients, and vulnerable populations will be referred to simply as ‘clients’; and staff, volunteers, students will be referred to as simply ‘staff’ throughout this document.

Note: This Guidance is NOT intended for facilities in Alberta’s continuing care system which encompasses the Co-ordinated Home Care Program, Publicly Funded Supportive Living Facilities and Long-Term Care Facilities. Those facilities have healthcare delivered directly by AHS or by an AHS contracted Operator and are regulated under the provincial Continuing Care Health Service Standards. These facilities have their own, separate guidelines: *AHS Guidelines for COVID-19 in Congregate Living Sites.*

Territorial acknowledgement

The Euro Canadian province of Alberta is located within the Northern Prairies of Turtle Island (now known as North America). For thousands of years this has been home and gathering place to many peoples including, but not limited to, the Dené, Nakoda (Stoney & Sioux), Nehiyawak (Cree), Niistitapi (Blackfoot), Otipemisiwak (Métis), Anishinaabe and many more.

Treaties 6, 7 and 8, as well as Métis Nation of Alberta Regions 1-6 and 8 land-based Métis Settlements, are represented within Alberta borders. By nature of these living national and provincial legislative agreements, we are all partners in ethnogeographic governance, including health care and its delivery.

Indigenous communities have the right to self-determination in their health and health care provision, as supported by:

- United Nations Declaration on the Rights of Indigenous Peoples[1]
- Truth and Reconciliation Commission's Calls to Action[2]
- The Murdered and Missing Indigenous Women and Girls Report's Calls to Justice[3]

[1] UN General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples : resolution / adopted by the General Assembly*, 2 October 2007, A/RES/61/295, available at: https://www.refworld.org/docid/471355a82.html [accessed 13 April 2020]
[2] Truth and Reconciliation Commission of Canada. (2015). *Truth and reconciliation commission of Canada: Calls to action*. Truth and Reconciliation Commission of Canada.
[3] National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (Volume 1a).

2. GENERAL INFORMATION ABOUT COVID-19

COVID-19 is a new type of coronavirus that has not been previously identified in humans. In response to COVID-19, the Province of Alberta announced a state of public health emergency under the Public Health Act on March 17, 2020. The COVID-19 outbreak was declared a global pandemic by the World Health Organization (WHO) on March 11, 2020.

Up-to-date information on COVID-19 is available on the Alberta Health and Alberta Health Services websites. While this document provides some basic information and guidelines, the above websites provide the most current information for readers.

How is COVID-19 spread?

COVID-19 is mainly spread from person to person from larger droplets from coughing or sneezing, through direct or indirect contact.

- These droplets can land on people who are within 2 metres (6 feet). COVID-19 is not an airborne disease and cannot spread through the air over long distances or time.
- COVID-19 may also be spread by touching contaminated objects or surfaces, then touching your eyes, nose or mouth.

COVID-19 symptoms

COVID-19 symptoms are similar to influenza and other respiratory illnesses. As per the Chief Medical Office of Health orders, AHS expanded the list of symptoms for which all Albertans can be tested for COVID-19. Anyone who has these symptoms MUST isolate for a minimum of 10 days or until symptoms resolve, whichever is longer.

- Fever
- A new cough or a chronic cough that is worsening
- New shortness of breath or chronic shortness of breath that is worsening
- Difficulty breathing
- Sore throat
- Runny nose

Albertans who have any of the following symptoms are also now eligible to be tested for COVID-19. People with these symptoms are not required to isolate, but are strongly advised to stay home and minimize contact with others until they are feeling better.

- Chills
- Painful swallowing
- Stuffy nose
- Headache
- Muscle/joint ache
- Feeling unwell/fatigue/severe exhaustion
- Nausea/vomiting/diarrhea/unexplained loss of appetite
- Loss of sense of smell or taste
- Conjunctivitis (pink eye)

The symptoms list may continue to change so please be diligent in checking this page on the AHS website for the most current symptom list.

Most people experience mild symptoms and about 80% recover without needing specialized medical care. COVID-19 can cause serious illness in some people, and there is a risk of death in severe cases. Symptoms of serious illness include difficulty breathing or pneumonia.

While we are still learning about COVID-19, serious illness appears to develop more often in people who are older or have pre-existing conditions, like high blood pressure, heart disease, lung disease, cancer or diabetes.

On average, COVID-19 has resulted in 1 to 2 deaths per 100 cases (in comparison to influenza, which results in 1 death in every 1,000 flu cases).

COVID-19 testing

Testing is now available to any person showing symptoms of COVID-19, as well as asymptomatic people meeting specific criteria. Up-to-date information on COVID-19 testing is available on the Alberta Health and Alberta Health Services websites. Current eligibility for testing is here.

3. PREVENTION AND PREPAREDNESS

Alberta-wide prevention measures

The most effective ways for staff and clients to prevent spread of COVID-19 is through hand hygiene, respiratory etiquette and physical distancing.

Handwashing and respiratory etiquette

Use alcohol based hand sanitizer if it's available. If it isn't, wash hands often with soap and water for 15-30 seconds. Alcohol based hand sanitizer is the preferred infection prevention and control method except:

- when hands are visibly dirty (with food, dirt, blood, body fluids, etc.)
- before and after handling food, and when
- providing care for patients with diarrhea and/or vomiting.

Cover coughs and sneezes with a tissue and then throw away the tissue and wash your hands; or cough and sneeze into your elbow and avoid touching your eyes, nose and mouth.

Provide tissues and lined garbage bins for use by staff and clients (biohazard bags are not needed). No-touch garbage cans are best, if available.

Signs should be posted at entrances, shared washrooms, and common areas reminding staff and clients to clean hands and to cover their coughs and sneezes. For posters on how to clean hands, how to cover your cough and physical distancing go here.

CMOH Orders state that Albertans are legally required under public health order to isolate for:

- 14 days if they recently returned from international travel, are a close contact of someone with COVID-19.

During the 14 days, if the person becomes sick with cough, fever, sore throat, shortness of breath/difficulty breathing, or runny nose, they must isolate for an additional 10 days from the start of symptoms or until their symptoms resolve, whichever is longer.

- 10 days if they have a COVID-19 symptom (cough, fever, sore throat, shortness of breath/difficulty breathing or runny nose) that is not related to a pre-existing illness or health condition.
- 10 days if they are confirmed to have COVID-19, from the start of their symptoms, or until symptoms resolves, whichever is longer

Physical distancing

Physical distancing involves taking steps to limit the number of people clients and staff come into contact with, in order to limit the spread of COVID-19 and reduce the risk of getting sick. This is not the same as isolation. Individuals should keep at least 2 metres (6 feet) away from others wherever possible. See these information posters to support awareness and actions to help prevent the spread of COVID-19, including physical distancing.

To protect yourself and others:

- keep at least 6 feet (about the length of a hockey stick) from others when going outside
- avoid overcrowding in elevators, stairwells or other enclosed spaces
- wash or sanitize your hands after touching communal or highly used surfaces

Enhanced prevention strategies for shelters

During this time, all shelters are being asked to help prevent the spread of COVID-19. This can be done in a variety of ways, depending on the type of shelter (e.g., group care shelters, women's shelters). The following sections will provide information on how to prevent the spread of COVID-19, and how to prepare in the case of an outbreak.

Contingency planning – site specific action plan in case of an outbreak

In addition to hand hygiene and physical distancing (see below), it's also important for each shelter to implement other measures to manage the COVID-19 pandemic.

It is strongly recommended that each shelter and surge capacity facility develop their own site specific plan to deal with an outbreak. Resources for the development of these plans are available on the Alberta Health and Alberta Health Services websites. The Alberta Emergency Management Agency provides additional resources. These plans should include key preventative measures, planning for an outbreak reflective of staffing, infrastructure, supplies, communication and recovery planning.

These measures may include:

- Extending shelters hours if possible and applicable
- Identifying how the shelter will continue to provide essential services and meet the needs of vulnerable populations
- Knowing where clients will be referred if shelter space is full, or if they need to be transferred to an external isolation site
- Knowing the isolation sites and the transportation methods (approved by a Medical Officer of Health [MOH] or designate) available for transfer
- Cross-training current employees or hiring temporary employees
- Identifying critical job functions and positions to plan for alternative coverage if a large number of staff have to isolate
- Identifying short-term volunteers to staff the shelter with higher usage or for alternate sites (isolation or decanting sites)
- Considering the need for extra supplies (e.g., food, toiletries, etc.), surge staff, and ensuring they have PPE

Appendix 2 includes a pandemic checklist for shelters to use in conjunction with the above resources.

Client and visitor registration and surveillance

Shelters should strongly consider implementing the following to help with tracking and screening of clients and visitors:

- A system registering all clients and visitors entering the facility, including names and contact information if available, in order to facilitate contact tracing in the event of an exposure, if appropriate.

- A system to track who is assigned to what section/cohort/bed (where possible) to more easily determine others who might have been exposed in an outbreak situation.
- Daily screening with regular clientele to see if they are experiencing any new symptoms that may have developed since the previous day. Early identification of symptomatic clients will help to limit the spread of COVID-19 within the facility.
- Daily tracking of the number of clients:
    - staying each night
    - with clinical symptoms
    - referred for COVID-19 testing or to an isolation site
- If tracking requires more resources, work with relevant stakeholders as required.

Discourage movement of clients between shelter sites and within the shelter site

Over the course of a day, one individual may visit several agencies. During a pandemic, this high mobility is discouraged in this population.

Strategies to reduce individuals' mobility include:

- limiting the movement of clients such as transfers between shelters
- limiting the number of clients or visitors at drop-ins or other day programs
- canceling or postponing group activities if they are not essential
- providing incentives to reduce mobility; for example, re-organizing services so that three meals are offered at one facility, instead of one meal each at three different agencies
- Implementing policies to encourage or require clients to access an assigned shelter and not others

Physical distancing within shelters for clients who do not have COVID-19 symptoms

Sleeping arrangements

Shelters throughout the province serve different communities and populations and some have more space and beds than others. It is recognized that while there are space limitations in many shelters, they provide a necessary service to vulnerable Albertans. Taking this into account, the following guidelines have been put in place by the provincial government.

- Head-to-toe placement of beds, mats or cots 2 metres apart, if space allows
    - However, the minimum requirement for head-to-toe placement of mats, cots and beds is 1 metre according to the exception within shelter spaces and temporary or transitional housing during a non-outbreak situation.
- If space allows, put fewer clients within a floor/dorm/unit.

- Arrange beds so that individuals lay head-to-toe or use neutral barriers that can be cleaned (foot lockers, non-porous barriers) between beds.
- Assign and track clients to a specific sleeping mat or sleeping unit to help with contact tracing should a client later test positive for COVID-19.

Mealtimes

Stagger mealtimes to reduce crowding and enable physical distancing in shared eating facilities

- Stagger the schedule for use of common/shared kitchens
- Provide bagged meals for clients to take away
- Stagger meals to specific cohorts/groups and floors

Bathrooms and bathing

Create a staggered bathing schedule to reduce the amount of people using the facilities at the same time. Frequent (at least three times a day) cleaning and disinfecting of shared bathroom facilities is recommended.

Recreation/common areas

For shelters that operate on a 24 hour basis, shelters must facilitate 2 metres of physical distance between clients during normal daytime operations.

Create a schedule for using common spaces and when possible, reduce activities that involve several clients at once; opt for more frequent smaller group activities when at all possible.

A Chief Medical Officer of Health (CMOH) public health order states that indoor gatherings of more than 15 people is prohibited, this does not apply to the normal operations of shelters and temporary or transitional housing settings. However, risk mitigation strategies such as physical distancing must be in place.

Transport

If transportation is required to get clients to other facilities or for obtaining other supports or services, opt for transporting fewer people per trip and ensure that passengers have more space, 2 metres if possible, between one another to reflect physical distancing recommendations. As this may not be possible, transport cohorts/groups of clients who reside together in the shelter, as a group to avoid intermingling. Symptomatic clients should wear a mask and clean their hands prior to transport.

Grouping clients who do not have COVID-19 symptoms

Grouping (also called cohorting) is a process of keeping clients who do not have symptoms of COVID-19 together. The purpose of grouping clients, in this instance, is to be able to isolate clients more effectively if a client starts to show symptoms of COVID-19. Grouping clients ensures that if one member of the cohort becomes positive for COVID-19, the entire cohort can be isolated together. The smaller the group the easier it will be to identify clients who may have come in contact with a COVID-19 positive client, trace additional contacts the cohort may have had with others including staff, and collectively isolate the group.

Environmental cleaning/disinfection measures during COVID-19

Cleaning refers to the removal of visible dirt, grime and impurities. While cleaning does not kill germs it is extremely effective in removing them from a surface. Disinfecting refers to using chemicals to kill germs on surfaces. This is only effective after surfaces are cleaned.

Cleaning and disinfection are both important to reduce the spread of infection. Use a disinfectant that has a Drug Identification Number (DIN) and a virucidal claim, meaning the product is effective in killing a specific virus or viruses. Alternatively, you can prepare a fresh bleach water solution with 20 ml of unscented household bleach in 1000 ml of water.

Health Canada has approved several hard-surface disinfectants for use against COVID-19. Use these lists to look up the DIN number of the product you are using or to find an approved product. Make sure to follow instructions on the product label to disinfect effectively.

Be sure to take the appropriate precautions when using chemicals for cleaning and disinfecting. Consult the products' labeled instructions and, if necessary, Material Safety Data Sheets. The labels of the cleaning and disinfecting products being used will likely identify what PPE staff or volunteers should use.

The following cleaning/disinfection measures should be taken, as much as possible, at shelters:

- All staff equipment (e.g., desks or tables, computer screens, telephones, touch screens, chair arms) at least daily and when visibly soiled. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.
- Conduct regularly scheduled and frequent cleaning and disinfection of common areas and surfaces in the facility, especially high-touch surfaces like door knobs, light switches, railings, tables, chairs, etc. This is recommended a minimum of three times per day.
- Clean and disinfect all equipment and environmental surfaces between use (e.g., shared equipment, tables).
- Clean and disinfect sleeping mats after every use (e.g., each morning). Store mats in a manner that prevents contamination (e.g., in a separate space not accessed by clients).
- Remove all communal items that cannot be easily cleaned, such as newspapers, magazines, and stuffed toys.
- Try to limit personal belongings that clients bring into the communal space. Clients should only have essential personal belongings.
- Where possible, clients should be provided a dedicated storage space (e.g., locker, plastic bin with lid), in which to store their personal belongings. The storage unit should be cleaned and disinfected before being assigned to another client.
- Clients should be encouraged not to share personal belongings.
- Staff should wash their hands after handling clients' belongings, if it isn't common practice to wear gloves when handling client belongings.
- Use care if handling laundry. Have a system to keep dirty laundry separate from clean laundry.

- Staff or volunteers handling laundry should wear gloves and gowns, if available. Try not to shake dirty sheets, blankets or pillows.

Ensure that there is an adequate supply of cleaning and disinfection supplies on hand. Store all disinfectants out of the reach to prevent consumption from individuals (e.g., children, pets).

Food handling

Practice routine food safety and sanitation practices. Germs from ill clients and staff (or from contaminated surfaces) can be transferred to food or serving utensils. Facilities should reinforce routine food safety and sanitation practices. Where possible, minimize client handling of shared food and utensils.

Food handling tips

- Dispense food onto plates for clients
- Minimize client handling of multiple sets of cutlery
- Remove shared food containers from dining areas (e.g., shared pitchers of water, shared coffee cream dispensers, salt & pepper shakers, etc.)
- Dispense snacks directly to clients and use pre-packaged snacks only
- Ensure that food handling staff are in good health and practice good hand hygiene.
- Ensure that all surfaces of the tables and chairs (including the underneath edge of the chair seat) are cleaned and disinfected after each meal
- Staff assigned to housekeeping duties should not be involved in food preparation or food service, if possible

4. SCREENING

Albertans experiencing COVID-19 symptoms are strongly encouraged not to visit a hospital, doctor's office, or health care facility without having called Health Link 811 first. This also applies to shelter staff, clientele and visitors. If someone is seriously ill and needs immediate medical attention, call 911. Be sure to inform them of any COVID-19 symptoms.

Just like any Albertan, if any staff, client or visitor at shelters has symptoms of COVID-19 (fever, cough, shortness of breath/difficulty breathing, runny nose and sore throat) that are not related to a pre-existing illness or health condition, they must isolate for a minimum of 10 days from the start of their symptoms, or until their symptoms resolve, whichever is longer. The symptoms list may continue to change so please be diligent in checking this page on the AHS website for the most current symptom list.

If a person tests negative for COVID-19 and have no known exposure to COVID-19, they are not required to isolate. For more information about actions and testing for COVID-19, use the AHS online assessment tool for the public and for shelter staff use this AHS online assessment tool that is for healthcare workers, shelter and group home staff, and other essential workers.

There are two stages of screening: primary and secondary. Primary screening is done by shelter staff upon entry into the shelter for other staff members, clients and visitors. Primary screening staff wear surgical masks and eye protection if physical distancing is not possible. Hands should be cleaned between each client encounter. Secondary screening is done by AHS or a trained medical staff (if available at the shelter) and would likely only be done for clients. Both staff and visitors would be sent home to isolate if they had symptoms, and be asked to complete this AHS online assessment tool for members of the public and this AHS Healthcare worker, shelter and group home staff, and other essential workers use this online assessment tool for further guidance.

Screening staff upon entry

Upon arriving for work each day or shift, staff must be screened for any COVID-19 symptoms. Even if they worked the previous day, they should be screened for the onset of new symptoms that they may not have been experiencing the day before. The only exception is in the case of an emergency where stopping to be screened would negatively affect the reason for their entry (e.g. fire, police, medical emergency).

Screening clients upon entry

Clients entering the site must be screened each time they enter, for COVID-19 symptoms as noted in Figure 1 below. The only exception is in the case of an emergency where stopping to be screened would negatively affect the reason for their entry (e.g. fire, police, medical emergency).

For clients who have routine interaction with shelter staff, staff should actively screen the client for COVID-19 symptoms daily, using the process outlined below.

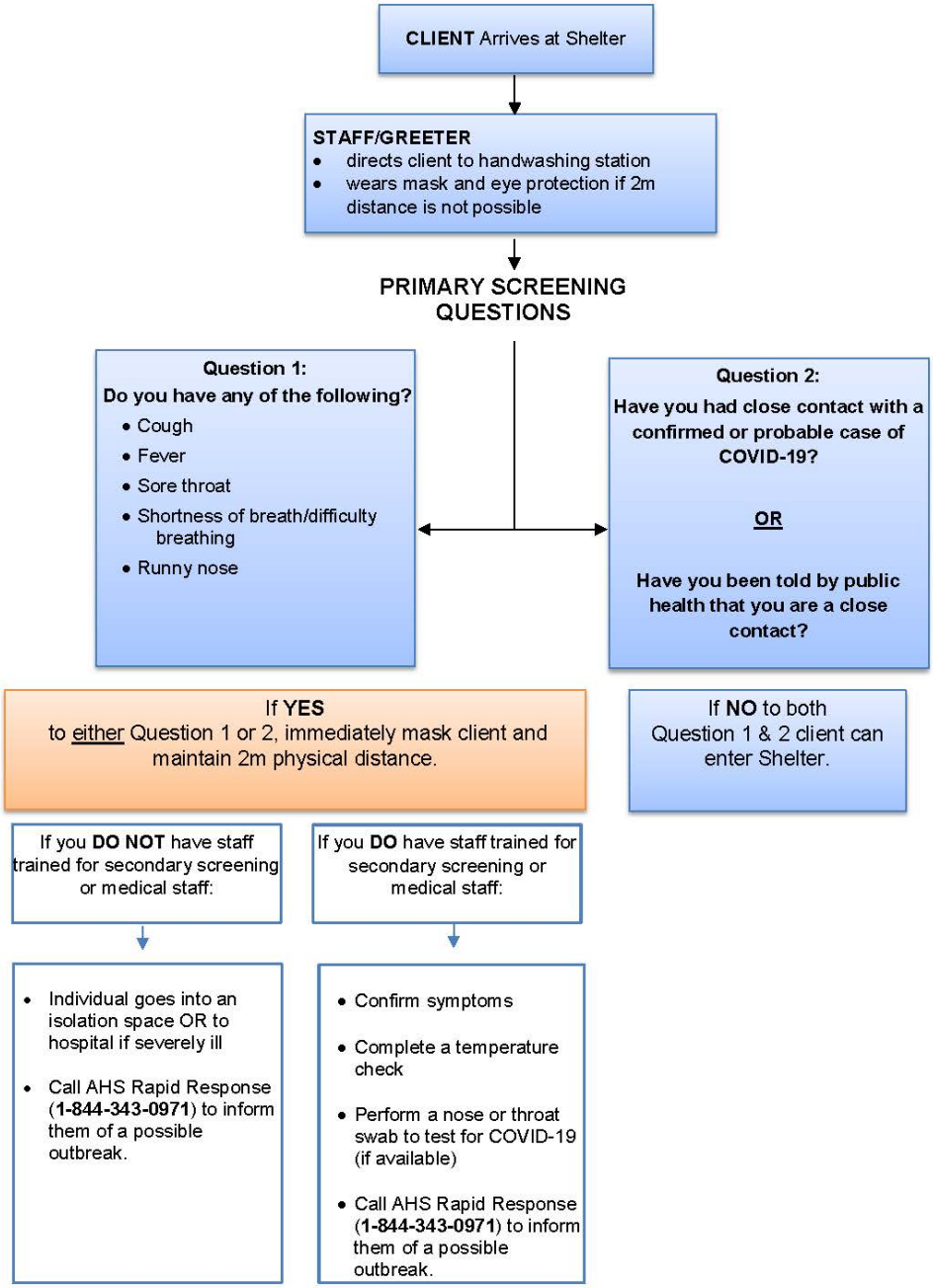
For clients who do not have routine interaction with shelter staff, staff must advise that they are required to conduct daily self-checks for symptoms of COVID-19. They can be given the client screening questionnaire for reference.

Screening visitors upon entry

If shelters are accepting visitors, staff should perform primary screening on entry into the shelter following the same guidelines as for clients.

Providing some indication that clients and visitors have been screened, such as a stamp or paper wristband, may be helpful, especially for clients who leave the premises and return within short timeframes (e.g., to smoke). They would be expected to do hand hygiene on re-entry, but the stamp would avoid them having to do a repeat screening. The stamp should be applied after clients have appropriately cleaned their hands.

Figure 1 provides an example of how to flow clients through primary and secondary screening. The symptoms list may continue to change so please be diligent in checking this page for updates. These symptoms that are screened for below, are those that could trigger an outbreak and require notification to AHS Coordinated Response line.



Primary screening

Staff should direct all clients to a designated screening area while maintaining the 2 metre distance at all times. The following questions are asked in primary screening:

1. Do you have the following COVID-19 symptoms: cough, fever, sore throat, shortness of breath, difficulty breathing, or runny nose?
    a. It may be hard to know if these are new symptoms or are ongoing symptoms. The secondary screen with a health care worker can help distinguish this.
2. Have you had close contact with a confirmed or probable case of COVID-19? OR have you been told by Public Health that you are a close contact?

If the client answers NO to all questions, the client can be admitted to the shelter.

- Maintain a 2 metre physical distance, encourage hand hygiene, and ask the client to inform staff if they begin to feel unwell.

If client indicates YES to any of the symptoms:

- Maintain a 2 metre physical distance, provide a surgical mask to the client, and talk them through the process of putting it on.
- If a client is unable to don the mask themselves, staff may help. Staff must discard gloves and put on new ones immediately after helping a client with donning.
- If possible, place the client in a private/separate space within the shelter.
- Proceed to the secondary screening process described below.

Secondary screening

If a client answered YES to either question in the primary screen, a secondary screening will be completed by a health professional (preferable) or trained shelter staff using appropriate PPE (gloves, gown, mask and face shield or eye protection).

No trained or medical staff on site

If the shelter does not have trained medical or shelter staff, and a client answered YES to either question in the primary screen:

- Isolate the individual as described above. All clients who are symptomatic can be tested.
- Contact the AHS Coordinated COVID-19 Response line at **1-844-343-0971** for additional guidance and decision making support if a client has one of the following symptoms:
    - Fever
    - A new cough or a chronic cough that is worsening
    - New shortness of breath or chronic shortness of breath that is worsening
    - Difficulty breathing
    - Sore throat
    - Runny nose

- The AHS Coordinated COVID-19 Response line must be contacted with the **first** symptomatic person (client or staff) who indicates they have any of the symptoms listed above. These particular symptoms could trigger an outbreak and thus, are the most important to screen for.
- The AHS Coordinated COVID-19 Response line should only be contacted with **new cases that are suspected** in a site that has not received laboratory results yet.
- If the site has laboratory confirmed COVID-19 cases, then the AHS Outbreak Management team (under the authority of the MOH) will be the contact for any new or suspected cases and they will give their contact information to the shelter.
- Call Community and Social Services (CSS) to inform them that the site is under investigation for a possible outbreak.

Trained or medical staff on-site

If your site has trained medical or shelter staff:

- Confirm COVID-19 symptoms (and understand them within the context of the client's pre-existing medical concerns).
- Complete a temperature check (shelter staff may assist with this if they are trained to do so). Temperatures of 38.0 °C or over are high. Normal temperatures are 35.8-37.9°C (96.4-100.4°F) for the ear or forehead.
    - Anyone with a measured temperature of 38.0 C or higher MUST be transferred to an isolation space
- Where available and appropriate (if staff have the ability to perform the testing), perform a nose or throat swab to test for COVID-19 for all symptomatic clients. If the staff are obtaining the swabs, then they will need to obtain an Epidemiological Investigation (EI) number – this can be obtained from the AHS Coordinated COVID-19 Response line at **1-844-343-0971**.
- Contact the AHS Coordinated COVID-19 Response line at **1-844-343-0971** for additional guidance and decision making support if a client has the following symptoms:
    - Fever
    - A new cough or a chronic cough that is worsening
    - New shortness of breath or chronic shortness of breath that is worsening
    - Difficulty breathing
    - Sore throat
    - Runny nose
- The AHS Coordinated COVID-19 Response line must assess the **first** symptomatic person (client or staff) who indicates they have any of the above symptoms.
- The AHS Coordinated COVID-19 Response line should only be contacted with **new cases that are suspected** in a site that has not received laboratory results yet.

- If the site has laboratory confirmed COVID-19 cases, then the AHS Outbreak Management team (under the authority of the MOH) will be the contact for any new or suspected cases and they will give their contact information to the shelter.
- Call Community and Social Services (CSS) to inform them that the site is under investigation of a possible outbreak.

AHS Coordinated COVID-19 Response Line

The AHS COVID-19 Coordinated Response Line for Congregate Living Settings at **1-844-343-0971** is for any group or communal living setting (including shelters, long term care facilities, group homes, etc.). This number is staffed by AHS and is available every day from 8 a.m. to 10 p.m. Callers are instructed to leave a message and all attempts will be made to call back within two hours. Calls placed between the hours of 10 p.m. to 8 a.m. will be returned the following morning after 8 a.m.

This is the number to call when there is a suspected or confirmed case or outbreak in a facility. AHS COVID-19 Response team will do the following:

- Ask a comprehensive list of questions about shelter setting, address, number of clients affected with symptoms, client names, need for swabbing assistance, need for PPE, ability to isolate, etc.
- They will provide the shelter with key actions to take until the AHS Outbreak Management Team under the direction of the MOH contacts the shelter.
- They will then submit the information to the MOH and the AHS Outbreak Management Team (as well as for a request for PPE and swabbing assistance if needed).
- The AHS Outbreak Management team will follow up on laboratory results and then contact the shelter about next steps. The AHS Outbreak Management Team determines if an outbreak will be declared, what outbreak measures will be implemented and when the outbreak will be declared over.

5. ISOLATION

Because COVID-19 is a new virus with no treatment or no known immunity in people who have not had it, it's critical for people with any symptoms and people who may have come into contact with the virus to stay 'home' and isolate to keep it from spreading.

Alberta is taking aggressive measures, including CMOH public health orders identifying particular restrictions and prohibitions, to help slow the spread of COVID-19. Law enforcement agencies now have full authority to enforce public health orders and issue fines for violations. The situation changes daily so each site needs to stay updated.

Where should clients be isolated?

On March 30, 2020, the CMOH of Health offered guidance for shelter clients who require isolation due to suspected or confirmed cases of COVID-19. Essentially, clients can be isolated two different ways: external to your shelter (recommended approach) or in isolation spaces within your shelter (less preferred approach). This section will outline these two options.

Isolation spaces external to shelter (recommended approach)

Different cities and zones have different solutions in place for where clients with symptoms of COVID-19 or are confirmed positive will go and how they will get there. As per Alberta's *Public Health Act*, spaces being used for COVID-19 isolation purposes and the transportation being used to transfer individuals requiring isolation, must be approved by a local Medical Officer of Health.

In April, the Chief Medical Officer of Health approved the use of commercial accommodations such as hotels, motels and inns for the purpose of COVID-19 isolation. However, these accommodations must adhere to standards set out in Directive D3-2020, and must be approved by a Medical Officer of Health. If isolation space isn't available, or more information is needed about getting clients to these sites, contact the zone-specific Program Advisor at CSS.

Alternatively, the vulnerable population representative identified in the AHS Zones may be contacted. The emails are as follows:

- Grande Prairie, Fort McMurray and surrounding areas: Zeoc.north.operations@albertahealthservices.ca
- Edmonton: Zeoc.edmonton.operations@albertahealthservices.ca
- Red Deer and surrounding areas: Zeoc.central.operations@albertahealthservices.ca
- Calgary: Zeoc.calgary.operations@albertahealthservices.ca
- Lethbridge, Medicine Hat and surrounding areas: Zeoc.south.operations@albertahealthservices.ca

Isolation space within a shelter (less preferred approach)

A client with COVID-19 symptoms should ideally be given access to a private room with four walls and a door. Additionally, a client should have access to their own bathroom.

Consult with the AHS staff when making decisions about co-housing or cohorting clients together in one space. Space cohorting refers to the process of assigning specific geographic areas within the shelter space for specific clients (e.g., clients with no COVID-19 symptoms in one area, those with symptoms in another).

If individual rooms are not available and if you have multiple clients needing to isolate, it may be possible to put the clients together in the same room, provided that adequate spacing of at least 2 metres can be ensured.

Consider using a large, well-ventilated room where beds are spaced apart as much as possible (2 metres or more). Clients may sleep head-to-toe and temporary barriers between beds, such as plastic sheeting, may be used. Plastic sheeting does become a source of contamination when it is touched, sneezed or coughed on, so consider changing it frequently.

Those with COVID-19 symptoms should avoid contact with other clients/residents and avoid common areas.

What does isolation look like for clients in these settings?

People who are in isolation due to symptoms or exposure:

- Must avoid situations where they could come into contact with and infect other people by using physical distancing, wearing face masks if transportation is needed, and following the guidance in this document. Transportation methods and conditions need to be approved by the MOH or designate.
- Should not participate in small group activities or use common/communal areas. An exception to this is where certain clients would not manage well mentally and behaviourally in complete isolation. Discuss this with your zone MOH.
- Are not allowed to leave the property where they are isolating and should avoid close contact with other clients and staff.
- If an individual leaves against public health recommendations, they should be advised that they could face fines and other more serious repercussions. If they leave, they should wear a mask at all times, avoid coming within 2 metres of others, and should NOT take public transit. They cannot re-enter their regular shelter space, but will be allowed to re-enter an isolation facility/space.

Staff responsibilities in shelters with internal isolation spaces

Minimize movement of staff between floors or areas within the shelter, especially if floors or areas have been assigned for those with symptoms and those without symptoms. Staff cohorting or assigning staff to work specifically with clients with no symptoms, while assigning others to clients with symptoms should be considered, if it is practical in the setting.

During this time, it's important that both the shelter caregivers (i.e. staff) and clients monitor their health for symptoms like worsening fever or cough, as well as shortness of breath, and that they call Health Link 811 if they have any concerns. If clients have access to their own phone, they can use it to communicate with the shelter staff and for check-ins with their health care provider.

Monitoring of ill clients should occur twice a day, at the very least. This includes verbal check-ins. If symptoms worsen, check-ins should increase.

Domestic items such as dishes, drinking glasses, cups, eating utensils, towels, pillows, or other personal items should not be shared with other people in the facility. After using these items, wash them thoroughly with soap and water, place in the dishwasher for cleaning and sanitizing, or wash in the washing machine.

Clients need access to food, drinks, and medications and these should be provided by shelter staff. During any interaction staff MUST wear appropriate PPE. Appropriate PPE includes mask and eye protection, at a minimum, if providing direct face-to-face care within 2 metres of the ill person. For more information please see the PPE instructions on the Alberta Health Services website.

The following resource about caring for COVID-19 patients are home, may be helpful for staff and clients. Shelters should comply with their typical standards of practice with regards to the client's:

- needs to refill prescriptions
- risk of flight, behavioural concerns, medical complexity, and mental health concerns
- aggressive, violent, or non-cooperative behaviours

If a child requires isolation in your shelter:

- Try to have one person only care for the sick child so others are not exposed.
- If a sick child is over 2 years old and can tolerate a cloth face mask without finding it hard to breathe, have them wear one. Don't leave the child alone while they're wearing a cloth face covering. The caregiver should wear a face mask when in the same room as the child.
- Help the child get plenty of rest and drink lots of liquids.
- Watch for signs that the child might need more medical help, such as trouble breathing, fast breathing, sleepiness, not being able to drink a lot of liquids, or signs of dehydration like peeing less than usual.

The following information around harm reduction practices, supporting people who use substances and telemedicine supports for addiction services during the COVID-19 pandemic, may be helpful to shelter operators and staff

- Community Based Naloxone program information how to order the kits: www.ahs.ca/naloxone
- *Harm Reduction and COVID-19: Guidance Document for Community Service Providers*
- Nicotine Replacement Therapy (NRT) kits can be ordered by emailing tru@ahs.ca as needed. After the 14 days those wanting to continue to use cessation medication can access it through their government benefits program or by calling the AlbertaQuits Helpline **1-866-710-7848.**

Enhanced environmental cleaning/disinfection if client is isolating onsite

Continue the general environmental cleaning/disinfection measures during the COVID-19 pandemic outlined earlier in this document.

Cleaning staff who are required to enter into the room or space of an isolated person, should do so using gloves, mask, gown and eye protection.

The frequency of cleaning and disinfecting 'high touch' surfaces (e.g., doorknobs, light switches, call bells, handrails) in resident rooms and common use areas should be done at least three times a day. Equipment should be cleaned and disinfected only with consideration for the procedures outlined by both the equipment manufacturer and the disinfectant labeled instructions.

In addition, cleaning and disinfecting of all low touch surfaces (e.g. shelves, bedside chairs and benches, windowsills, over-bed lighting, message or white boards, etc.) should happen at least once per day.

Conduct a thorough, enhanced cleaning of all environmental surfaces in the isolation room after the person is no longer in isolation.

6. DEALING WITH OUTBREAKS IN SHELTERS

What is a COVID-19 outbreak?

A **confirmed** COVID-19 outbreak is defined as any one client or staff member (who has worked at the site while they were infectious, even if they didn't get the disease on site) confirmed to have COVID-19.

If there is a new confirmed outbreak of COVID-19, it is required that all residents and staff on the affected site/unit be tested for COVID-19.

- The swabs should be collected within 3 days of identifying the first confirmed case
- The swabs will be collected, preferably, through on-site capacity, if available. If not, AHS will arrange for the client to be tested.
- This testing should also occur if there appears to be transmission still occurring in an existing outbreak.
- Testing may be required at other shelter sites, if the positive client had visited other shelters.

When an outbreak is declared at a shelter, it is strongly recommended for the operator to try to the best of their ability, to ensure that staff are only working at the one site for the duration of the outbreak.

A **site under investigation** is defined as a site where at least one resident or staff member exhibit any symptoms of COVID-19.

Roles and responsibilities during an outbreak in shelters (including shelter surge capacity sites)

Alberta Health Services (AHS)

In the event of an outbreak in a shelter, AHS Outbreak Management staff, under the direction of the MOH will collaborate with partners to determine next steps.

AHS staff will work with shelter operators and staff to support the implementation of the outbreak management plan. Isolation spaces and transportation methods and conditions need to be approved by the MOH or designate.

Examples of actions led by AHS may include the following, depending on situational circumstances:

- Providing shelters with information on how to identify a potential COVID-19 positive client.
- Advising shelter operators on enhanced infection prevention control measures including hand washing, physical distancing advice, and education on putting on and taking off PPE.
- Investigating any COVID-19 cases and recommending measures to limit spread within shelter.
- Providing consultation on suspected clusters of illness or outbreaks.
- Setting standards for how shelters must support disease surveillance.
- Working with clients and shelter operators to identify and locate close contacts.
- Assisting with testing of symptomatic clients for COVID-19, including delivery of specimen to laboratory.

Each zone in AHS is accountable for the above roles, and reports directly to the Zone Emergency Operations Centre (ZEOC). Each ZEOC reports directly to the AHS Emergency Coordination Centre (ECC).

Government of Alberta

Community and Social Services, as the funder of shelters in the province, and Alberta Health, as the department responsible for setting policy direction and developing CMOH public health orders, will work together with AHS and shelter partners in efforts to prevent and manage COVID-19.

Shelter operators

Shelter operations will continue to manage day-to-day operations, and ensure appropriate staffing levels and collaborate with other stakeholders if more resources are required. They will also implement and maintain a process for screening, isolating, and transporting clients as necessary.

Report a COVID-19 case or suspected case by calling the AHS COVID-19 Coordinated Response Line for Congregate Living Settings at **1-844-343-0971**. Early recognition of unusual clusters of illness and swift actions in response to these episodes are essential for effective management of outbreaks. The notification of outbreaks and other infectious disease threats in Alberta is legislated under Alberta's *Public Health Act*. Notify CSS about a possible outbreak.

Control measures during COVID-19 outbreaks

In an outbreak situation (one or more cases), AHS outbreak management staff, under the direction of the MOH will collaborate with partners to provide guidance on next steps and ongoing support for the shelter during this process.

It is acknowledged that limited staffing, physical layout, shared accommodation, and communal areas in shelters may pose challenges for implementing all of these recommendations and requirements. It is also anticipated that each shelter or facility may develop their own site-specific options to meet the recommendations of the MOH or designate when developing their contingency plans for outbreaks of communicable diseases.

Immediate implementation of the following measures are required to limit the infectious spread:

- Isolate symptomatic clients
    - Do not permit mingling with others. This includes enforcing restrictions on isolated client movements, and limiting access within the facility to only their assigned floor/space.
    - Designate a washroom solely for use by isolated clients. Cleaning and disinfection should occur with greater frequency (between every client use, or hourly if that is not possible).
    - Continue meal support to the cohort and other essential service provision to the clients while ensuring appropriate infection control measures.
    - If separate isolation spaces for each client cannot be provided, clients can be placed in a group setting. In regards to sleeping arrangements, ensure that there is at least 2 metres of spacing between clients.
- Identify potentially exposed clients and staff who may have come in contact with the COVID-19 positive client.

- Isolate this client cohort/group and the space they are in immediately, limiting in and out access to the cohorted space. If added support in identifying cohorts is required, the AHS outbreak management team can provide guidance. AHS will also work with staff to determine who has been in contact with the COVID-19 positive client and assess the isolation needs for staff.
- Consider cohorting of staff.
- Limit staff-to-client interaction as much as possible and ensure staff wear appropriate PPE.
- Report timely updates to the Zone MOH or Outbreak Management Team member as directed.
- Testing of symptomatic clients and staff will be under the direction of the outbreak management team.
- Communicate with administration, staff, other services providers and volunteers regarding the outbreak and initiation of the investigation by AHS Public Health, including other facilities at the site (e.g., child care facility). During an outbreak investigation, it's important to take the following steps:
    - Work collaboratively with AHS, AH, CSS, municipalities, and other partners to provide additional human resource support where required including added security, cleaning support staff, food services, police support, and medical and health supports.
    - Educate clients on what an outbreak means and provide supportive guidance on how to maintain their health and wellbeing during the outbreak.

Environmental cleaning/disinfection measures during an outbreak

Please see the Environmental cleaning/disinfection measures during COVID-19 section in this manual. Many of the same cleaning principles apply. Additional care is required to clean isolation rooms or areas and the frequency of cleaning may need to increase during an outbreak. Consider all surfaces in the client isolation environment as contaminated.

Remember that cleaning and disinfecting all equipment and environmental surfaces between use (e.g., shared equipment, tables) is essential. This includes cleaning and disinfecting sleeping mats after every use (e.g., each morning) and storing mats in a manner that prevents contamination such as a separate space not accessed by clients.

Ensure that there is an adequate supply of cleaning and disinfection supplies on hand.

Food handling during an outbreak

Many of the same principles of food handling for prevention are followed during an outbreak. Please see the food handling tips in the earlier section as well as the information from AHS about routine food safety and sanitation practices.

Whole facility isolation and lockdown

Should the outbreak location not be contained to a section of the building and require complete facility isolation, the Zone MOH will work with partners to develop strict control measures. Controlling access to and from the building will need to be implemented. Security support may be required for monitoring access and controlled movement around the building. Ideally, positive incentives to maintain isolation should be considered first, including substance use management (refer to the *Harm Reduction and COVID-19: Guidance Document for Community Service Providers*), activities within isolation spaces, and smoking supports etc.

Only staff can have access to and from the facility during the outbreak, and PPE recommendations for staff within the facility will be made by the Zone MOH. Additional plans will need to be implemented to bring in staff to replace those who have been exposed and who need to isolate at home.

Identify and place more sick or unwell clients in areas where more supervision can occur. This will ensure clients are closely watched for worsening health symptoms, and medical supports can be provided where necessary. Where possible, provide independent isolation spaces to clients. This could be in the form of a private hotel unit or a cohorted isolation space. Isolation spaces need to be approved by the MOH or designate. If this measure is employed, ensure adequate amount of psychosocial and medical/pharmacy support for highly vulnerable clients.

Clients who have left the shelter space before the outbreak occurred may be considered a contact. The AHS outbreak team will provide guidance and messaging around how to manage these clients.

If you have any questions or concerns about the guidelines contact the Zone MOH/designate in your area (see Table 1). Contact Alberta Health Services with questions about training and educating staff, if needed.

When a client returns after being in isolation

In a shelter without an outbreak

Should a client finish their assisted isolation, they can return to the facility after being cleared by a health care professional and AHS outbreak management team (for example, notification to shelters as to who is medically cleared and are free to return to their shelter or community). A discharge letter may be provided to the client indicating that they have been medically cleared and are free to return to their shelter or community.

Regular primary screening (by shelter workers) and secondary screening (by health staff) should continue with the client.

If the recovered client develops new symptoms, which are consistent with COVID-19, they should be reassessed and isolated again if necessary. These instructions can be included in the suggested discharge letter as well.

During an outbreak

The Zone MOH will determine when an outbreak is declared over. Clients can return to a facility provided that they do not enter a cohort or group that is isolating. If their entire home facility is in lockdown, the client cannot return and alternative shelter/housing options will need to be provided for the client.

Post outbreak clearance process

Guidance around clearing the outbreak and returning to regular operations will be provided by the AHS Outbreak Management Team. Regular screening and prevention activities for COVID-19 would resume at this point.

Alberta Health Services

Table 1: Zone Medical Officer of Health/designate

AHS ZONE (Link to Zone MOH)		**REGULAR HOURS** Business hours may vary slightly from Zone to Zone, but are typically 8 a.m. – 4:30 p.m.			**AFTER HOURS**
Zone 1 South		Communicable Disease Control	CDC Intake	587-220-5753	(403) 388-6111 Chinook Regional Hospital Switchboard
		Environmental Public Health	EPH CDC Lead	403-388-6689	1-844-388-6691
Zone 2 Calgary		Communicable Disease Control	CDC Intake	403-955-6750	(403) 264-5615 MOH On-Call
		Environmental Public Health	EPH Disease Control	403-943-2400	
Zone 3 Central		Communicable Disease Control	CDC Intake	403-356-6420	(403) 391-8027 CDC On-Call
		Environmental Public Health	24 Hour Intake	1-866-654-7890	1-866-654-7890
Zone 4 Edmonton		Communicable Disease Control	CDC Intake Pager	780-445-7226	(780) 433-3940 MOH On-Call
		Environmental Public Health	EPH		
Zone 5 North		Communicable Disease Control	CDC Intake	1-855-513-7530	1-800-732-8981 Public Health On-Call

7. PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR SHELTERS

Encouraging staff and clients to sanitize their hands with alcohol based hand sanitizer or wash their hands often with soap and water for at least 15-30 seconds, covering their cough or sneeze and maintaining a physical distance of 2 metres is effective in minimizing the spread of COVID-19. Frequent hand cleaning is required even when wearing PPE.

PPE should only be used for the following purposes:

- Cleaning and disinfecting contaminated spaces.
- Screening clients and staff for COVID-19 (both primary and secondary).
- Working closely with clients where physical distancing is hard to maintain.
- Working closely with clients and staff who may have suspected or confirmed COVID-19.

What type of PPE is needed for which task?

During COVID-19, not all settings and jobs need the same PPE. The type of PPE required depends on the types of interactions and activities the staff have with a client. See the AHS document below that outlines which type of PPE is required when dealing with confirmed or suspected cases of COVID-19.

For shelter staff who work in administrative areas and do not have direct contact with clients, no PPE is required. Use physical distancing of 2 metres, wash your hands often and avoid touching your face.

Shelter staff who have direct contact with clients (e.g., talking to clients, screening clients for symptoms, distributing food and supplies) and who are unable to maintain/sustain a 2 metre physical distance with clients, should wear a surgical mask with a visor or a mask and eye protection continuously at all times and in all areas of the workplace (including staff offices or work spaces).

- Medical face masks (i.e. a surgical mask, also called a procedural mask) – Replace the mask if it becomes wet, damaged, or soiled. Do not re-use. Note: N-95 masks are not required in shelters.
    - These should be put on at entry to the site. Staff must perform hand hygiene before putting on the mask and before and after removing the mask.
- If the surgical mask doesn't include a visor, appropriate eye protection should be worn. Prescription eyeglasses are not considered eye protection. Some eye protection is used only once and others can be re-used after cleaning and disinfection (refer to the manufacturer's instructions to see which applies to your eye protection).
    - Where there is evidence of continued transmission (defined as at least 2 confirmed cases), continuous use of eye protection (googles, visor, face shield) is recommended for all staff and essential visitors.

For shelter staff, including cleaning staff, who interact with clients who are in isolation or awaiting transfer to an isolation location, the following PPE is required before entering the space or room where the client is located:

- Gloves – these are disposable after use, one pair one task. Clean hands before putting on and taking off gloves.

- Gowns, if available – once done with the gown, if disposable, place in a lined waste bin in or near the client's room.
- Medical face masks (i.e. surgical or procedural) – Replace the mask if it becomes wet, damaged, or soiled. Do not re-use. Note: N-95 masks are not required in shelters. See more information on masks at alberta.ca/covid19.
- If the surgical mask doesn't include a visor, appropriate eye protection should be worn. Prescription eyeglasses are not considered eye protection. Some eye protection is used only once and others can be re-used after cleaning and disinfection (refer to the manufacturer's instructions to see which applies to our eye protection).

Clients who show any COVID-19 symptoms and are awaiting secondary screening or being transferred to an isolation area should be provided with a medical face mask (i.e. surgical or procedural mask), if they tolerate it. N95 masks are not necessary.

How to use PPE?

Personal protective equipment (PPE) must be used correctly. Care must be taken when putting on and when taking off PPE. PPE cannot be re-used. The following links will provide more information about the right ways to put on and take off PPE:

Putting on and taking off gloves

Putting on PPE (glove, gown, face mask and eye protection)

- Note: 3b in the above link is not necessary in shelter settings

Taking off PPE

How to optimize PPE?

Shortages of PPE are posing a challenge, around the world and may be experienced in Alberta.

Here are a few ways to help with the shortages:

- Rely on other actions such as cleaning, handwashing, and maintaining physical distance to prevent the spread of COVID-19.
- Before using PPE, consider if it makes sense and is appropriate for the situation.
- Carefully prioritize PPE use for selected activities.

How to request PPE?

A request form is available here.

8. ADDITIONAL CONSIDERATIONS

Psychosocial Support

Clients affected by a disaster, such as a pandemic, will experience major changes in their lives. In the current pandemic this includes fear and anxiety regarding the illness in addition to the psychological impact of mitigation efforts such as isolation and changed living location and conditions. Although all Albertans will be impacted people facing additional social barriers will be more significantly impacted. Furthermore, people with pre-existing addictions or mental health concerns may experience their conditions becoming more acute (i.e., depression, becoming suicidal, inability to access substances in the usual manner resulting in unplanned detox and stress). Finally, clients may also be grieving for friends or family members and may have to deal with personal or family crises.

These impacts will be felt both by staff working with a vulnerable population as well. Staff may need to talk about their feelings and experiences or access employee support programs or online/phone mental health supports.

All organizations should develop strategies to increase psychosocial support for both staff and clients during a pandemic. For more information on mental health for everyone visit this link at AHS. Contact the local crisis team if needed. Additional supports appropriate for vulnerable populations with greater needs should also be implemented.

As noted above, the COVID-19 pandemic may have a significant impact on mental health and addiction.

Online resources are available if you need advice on handling stressful situations or ways to talk to children.

- Mental health and coping with COVID-19 (CDC)
- Talking with children about COVID-19 (CDC)
- Help in Tough Times (AHS)
- Wellness Together Canada https://ca.portal.gs/ (Health Canada)

If you need to talk, call the 24-hour help lines:

- Mental Health Help Line at 1-877-303-2642
- Addiction Help Line at 1-866-332-2322
- 211

Indigenous health considerations

Euro Canadian governments, including the province of Alberta and municipalities, have a responsibility to offer reciprocal accountability on Indigenous self-determination through substantive equality and equity in health promotion, prevention and care delivery.

Due to the historical and contemporary legacies of colonization, Indigenous peoples are disproportionately represented within social, psychological and biological comorbidities. Indigenous peoples continue to remain resilient despite experiencing systemic barriers that

result in increased rates of homelessness, limited income, food insecurity, and challenges in safety.

In regard to COVID-19, social interactions and housing circumstances deeply influence rates of transmission. Likewise, some Indigenous individuals, families and communities experience a higher rate of respiratory diseases such as asthma. These individuals may be more likely to experience more severe symptoms of COVID-19.

The facilitation of public health recommendations, like physical and social distancing and isolation, while reducing the rates of COVID-19 transmission, can also precipitate acute stress reaction and post-traumatic stress disorder stemming from personal and multi-generational trauma.

Supporting Indigenous peoples with no fixed address during the COVID-19 pandemic requires an understanding of the contemporary colonial landscape, healing-centered engagement (similar to trauma-informed approach), as well as decolonized and culturally centered approaches. For more information on COVID-19 and Indigenous Populations visit https://www.albertahealthservices.ca/topics/Page17101.aspx

Table 2. AHS Indigenous Health Zone Contacts

Name	Contact Information	Zone
Cai-Lei Matsumoto	Cai-Lei.Matsumoto@ahs.ca	South Zone
Shelley Goforth	Shelley.Goforth@ahs.ca	Calgary Zone
Tracy Lee	Tracy.Lee@ahs.ca	Central Zone
Mike Sutherland	Mike.Sutherland@ahs.ca	Edmonton Zone
Shelly Gladue	Shelly.Gladue@ahs.ca	North Zone

Family violence

If a client is at risk of family violence, help is available. Call the 24-hour Family Violence Info Line at 310-1818 to get anonymous help in over 170 languages.

Other resources:

- Family violence during COVID-19 information sheet
- Find information on shelter and financial supports
- Learn how to recognize and prevent family violence

Appendix 1: CMOH Public Health Orders and direction to shelter operators

On March 30, 2020, the CMOH offered the following exemptions and clarifications for shelter operators related to CMOH Orders:

Physical distancing in shelters for clients who do not have COVID-19 symptoms:

Under ideal circumstances, the 2 metre distance applies to the head-to-toe placement of mats, cots and beds, however, recognizing the current space limitations in many shelters and the necessity of providing adequate beds to vulnerable Albertans, the minimum requirement for health to toe placement of mats, cots and beds is 1 meter. For shelters that operate on a 24-hour basis, shelter operators must facilitate 2 metres of physical distance between clients during normal daytime operations.

Clients who require isolation due to suspected or confirmed cases of COVID-19:

Operators are encouraged to prioritize moving clients who have a suspected or confirmed case of COVID-19 to an external, assisted isolation space.

For shelters providing services for clients who are homeless, this may mean moving the client to an isolation space or facility that has been identified by shelter networks in various cities and locations around the province.

For clients who are facing family violence, have young children, or are mature minors, this may mean securing a hotel room for the client, or other suitable options that maintain client safety.

In the event that an operator of a shelter or transitional housing facility determines they have adequate space to set up a separate room or section specifically for client isolation or if a group of operators determined to designate one of their facilities as an isolation-only shelter; the operator(s) must follow the requirement, under CMOH public health orders, to ensure 2 metres of distance between people, including with sleeping arrangements.

AHS Public Health in each Zone should be consulted to ensure these spaces meet environmental health and infection, prevention and control standards. Additional occupational therapy home assessments can be conducted to determine if there are other concerns, which could limit clients from physically accessing the site especially for those who have mobility issues and weight concerns etc.

Appendix 2: Pandemic checklist for shelters

Preparing for and Preventing an Outbreak	○ Develop your site emergency plan • Identify key contacts for your site, municipality and zone • Identify available interim care locations for clients in case they are needed • Identify contingency plans for staff absenteeism • Create a communication plan for updating staff, clients, and others ○ Implement illness screening processes for clients and staff ○ Ensure that handwashing protocols, posters, and supplies are in place ○ Ensure that environmental cleaning procedures and supplies are in place ○ Ensure that appropriate PPE is available for staff ○ Ensure that physical spacing (2m of distance between all people) has been implemented throughout the site (including in sleeping and eating areas) ○ Limit access to, or close communal areas ○ Provide private bins or bags for storing clients' personal items ○ Provide masks to clients with respiratory symptoms ○ Communicate with staff about staying home when sick ○ Be prepared to contact AHS at **1-844-343-0971** for guidance when illness is identified ○ Be prepared to transport clients with serious illness to health care facilities ○ Identify spaces that can be used to isolate clients with mild illness, if possible ○ Identify mental health resources for staff and clients ○ Stay up-to-date at the Alberta Health and Alberta Health Services websites for COVID-19
During an Outbreak	○ Put your site emergency plan into action ○ Call your Outbreak Management Team member assigned to you when you have questions ○ Call CSS or your regulatory body to inform them of the possible outbreak ○ AHS MOH and the Outbreak Management team will collaborate with you to determine next steps. ○ Clients with mild respiratory symptoms should be isolated ○ Clients with serious respiratory symptoms should be transported to health care sites ○ Continue to communicate with staff and clients ○ Maintain preventative actions like cleaning, masking, handwashing, and physical distancing ○ Limit visitors to the facility ○ Use appropriate PPE when caring for clients with respiratory symptoms when physical distancing cannot be maintained

Resolving an Outbreak	○ AHS will determine when an outbreak is over ○ Make note of what worked well and what could be improved and update these items in your site's emergency response plan ○ Return to the "prevention" mode in the shelter ○ Continue to implement illness screening processes for clients and staff ○ Ensure that handwashing protocols, cleaning, and physical distancing are maintained until the COVID-19 pandemic ends

Appendix 3: Quick reference links to up-to-date information

Public Health Orders

Orders and legislation

COVID-19 Screening

Current eligibility for testing is here

Current symptom list is here

AHS online assessment tool

AHS online assessment tool for healthcare and shelter workers/enforcement personnel/first responders

COVID-19 Guidance: Daily Fit for Work Screening Protocol

Personal Protective Equipment (PPE)

How to request PPE

Modified PPE for Suspected or Confirmed COVID-19 in Vulnerable Populations outside of Healthcare Facilities

Caring for a Patient with COVID-19

How to care for a COVID-19 patient at home

Other Guidelines

Alberta Public Health Disease Management Guidelines

AHS Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites

Harm Reduction and COVID-19: Guidance Document for Community Service Providers

Supporting people who use substances in shelter settings during the COVID-19 pandemic: National Rapid Guidance

Telemedicine support for addiction services: National Rapid Guidance

Appendix 4: Frequently Asked Questions - Dealing with COVID-19 in communal or group settings

Who do I call if I suspect a client or staff has COVID-19 or has been confirmed to have it?
Call the AHS COVID-19 Coordinated Response Line **at 1-844-343-0971**. This number is for any congregate, communal or group living setting (this could include shelters, long term care facilities, group homes, etc.). This number is staffed by AHS and is open from 8 a.m. to 10 p.m. Callers are asked to leave a message and all attempts will be made to return the call within 2 hours. Messages can be left between 10 p.m. and 8 a.m. will be returned the following morning.

The COVID-19 Coordinated Response Line must be contacted with the **first** symptomatic of person (client or staff) who indicates they have any of the symptoms listed below.

- Fever
- A new cough or a chronic cough that is worsening
- New shortness of breath or chronic shortness of breath that is worsening
- Difficulty breathing
- Sore throat
- Runny nose

The COVID-19 Coordinated Response Line should only be contacted with **new cases that are suspected** in a site that has not received laboratory results yet.

If the site has laboratory confirmed COVID-19 cases, then the AHS Outbreak Management team (under the authority of the MOH) will be the contact for any new or suspected cases. The AHS Outbreak Management team will provide you with their contact information.

What should I expect when I call 1-844-343-0971?
When you call the AHS COVID-19 Coordinated Response Line for Congregate Living Settings, you can expect a team member to:

- Ask you a list of comprehensive questions about your communal or group living site, the symptomatic clients, isolation plans, need for swabbing assistance, need for PPE, ability to isolate, etc.).
- Provide the shelter with key actions to take until the AHS Outbreak Management Team under the direction of the MOH contacts the shelter.
- Submit the information to the MOH and the AHS Outbreak Management Team (as well as for a request for PPE, swabbing assistance if needed). The Outbreak Management team will follow up on laboratory results and contact the shelter about next steps. Then will determine if it is an outbreak, how it is managed and when it is closed.

What is considered an outbreak?
A **confirmed** COVID-19 outbreak is defined as any one individual confirmed to have COVID-19, including any resident or staff member.

What do isolation and quarantine mean for a person who lives in a congregate living setting?
Isolation and quarantine means a person is to stay within the communal or group living setting, either in the appointed isolation area, or offsite at a temporary isolation area affiliated with their typical congregate living space. If they have symptoms, a person needs to *isolate* for 10 days, or from symptom onset until symptoms have resolved, whichever is later. A person needs to be *quarantined* if they are a contact of a confirmed positive case or have a high risk of exposure to COVID-19. They must stay in quarantine for 14 days from the date of the exposure.

When an outbreak occurs in a shelter and it becomes locked down, are staff allowed to go home and then return to work the next day?
Yes. Staff are not included in the lockdown. If a staff member is symptomatic, they are to isolate at home. To the best of the shelter's ability, staff should be cohorted so they are only working in one area/on one floor/unit. Further, staff, just like clients and visitors, must be screened at the beginning of every day/shift.

How should clients who are confirmed COVID-19 be transported to an external isolation site?
How the client is transported to an external isolation site will depend on what has been coordinated in their specific AHS Zone, city, or region and approved by the MOH. Some AHS Zones have organized vans, taxis and public transport for this purpose. In each instance, proper disinfection protocols and use of PPE are necessary. If transportation plans aren't clear, contact the Zone MOH or other appropriate person/group for securing transportation.

Confirmation on the conditions of transportation need to be confirmed by the MOH, however, it is expected that the patient should wear a mask, if they can tolerate it, and their hands should be cleaned prior to entering the form of transportation. Whoever else is involved, whether it be drivers or health care staff, should wear appropriate PPE based on their ability to maintain distance in a vehicle (bus) or not (car/van/taxi).

Is it possible for a family to isolate in a women's shelter?
This is an option if physical distancing can be practiced and the shelter is able to provide food, medication, etc. However, families who choose to isolate together, must agree that whatever happens to the most ill family member, happens to the rest of the family. The length of isolation will be based on the sickest family member and the rest of the family needs to agree to that. Additionally, all family members need to agree to limit contact with anyone outside of their group to limit potential exposure to COVID-19.

Are clients who reside in a second stage shelter, where they have a private bedroom and bathroom, required to be screened daily?
Daily screening for this demographic is not mandatory, however it is encouraged to check in daily on clients both in regards to their physical health and social/emotional/mental state, if possible.

What are the guidelines around returning to work as a shelter staff?
There are many factors that need to be considered before returning to work at a shelter. This includes symptoms, contact, and isolation period. The AHS COVID-19 Return to Work Guide for Healthcare Workers and the AHS COVID-19 Return to Work Decision Chart for Healthcare Workers may be helpful in understanding when a staff is able to return to work.

Are shelter staff mandated to only work at one site?
Limiting staff to work at only one site during the COVID-19 pandemic is best practice and strongly encouraged wherever possible within shelter settings. While this has been mandated for other settings, such as long-term care facilities, it is **not** mandatory for shelters.

CURRENT AS OF JUNE 3, 2020

UPDATES ARE HIGHLIGHTED

2020

COVID-19 Practice Guidance for Service Providers in Supported Independent Living, Group and Residential Care in Alberta

ALBERTA CHILDREN'S SERVICES

ALIGN ASSOCIATION OF COMMUNITY SERVICES

ALBERTA HEALTH

Table of Contents

INTRODUCTION

This document is a Covid-19 Practice Guideline intended to inform service providers for children and youth in the care and custody of Alberta Children's Services. The information in this guideline was initially developed by Alberta Health Services March 2020 and intended for emergency homeless shelters; but is also applicable to other types of facilities as well as agencies providing services to marginalized and vulnerable populations. This document has been adapted by ALIGN and Children's Services to meet the needs of Children's Services at this time. This document consolidates and outlines general recommendations to prevent the spread of COVID-19 in these settings.

Where operationally applicable the guidance contained in the orders of the Chief Medical Office of Alberta Health (CMOH) is being followed. However, Children's Services licensed group homes and residential facilities are licensed under the Child, Youth and Family Enhancement Act (CYFEA) and are not licensed under Alberta Health.

Where the practice guidance in this document is not consistent with CMOH orders, Children's Services has consulted with Alberta Health for their input and advice to ensure that it follows sound principles related to infection control and precautionary measures.

It is acknowledged that limited staffing, physical lay-out, shared accommodation, communal areas and programming may pose challenges for implementing the recommendations outlined in this document. Facilities are encouraged to customize and prioritize as necessary.

PLEASE NOTE: This guidance is only current as of the date of the time stamp on the front page.

The situation continues to change rapidly. To stay current on the most recent public health recommendations related to COVID-19 in Alberta, please visit **Alberta Health** or **Alberta Health Services (AHS)**

Organizations dedicated to housing and homelessness issues may also be good sources of information. Recent examples from Canada include:

- **Canadian Alliance to End Homelessness (CAEH)**
- **Homeless Hub**

These Guidelines are to compliment your Business Continuity and Essential Service Response Plans and may provide new information/resources regarding the unique challenges the COVID-19 pandemic presents for all of us.

GENERAL INFORMATION ABOUT COVID-19

Coronaviruses are a large family of viruses. Some coronaviruses cause respiratory illness in people, ranging from common colds to severe pneumonias. Others cause illness in animals only. COVID-19 is a novel coronavirus that had not been detected previously in humans. It is the cause of the respiratory outbreak in China that has now been spreading in most countries around the world, including Canada.

Most people recover from this disease without needing special treatment. However, it can cause serious illness in some, and there is a risk of death in severe cases. Those who are older and those with other medical problems (such as high blood pressure, heart disease, lung disease, cancer or diabetes) are more likely to develop serious illness, which can include difficulty breathing and pneumonia. There is currently no specific vaccine or **treatment** for COVID-19.

Symptoms

Symptoms are similar to influenza and other respiratory illnesses. Common symptoms include:

- Fever (over 38 degrees C)
- Cough
- Shortness of breath/Difficulty breathing
- Sore throat
- Runny nose

Additional Symptoms can include:

- Stuffy nose
- Painful swallowing
- Headache
- Chills
- Muscle or joint aches
- Feeling unwell in general, or new fatigue or severe exhaustion
- Gastrointestinal symptoms (nausea, vomiting, diarrhea or unexplained loss of appetite)
- Loss of sense of smell or taste
- Conjunctivitis, commonly known as pink eye

AHS Coordinated COVID-19 Response Line – 1-844-343-0971

AHS Coordinated COVID-19 Response Line for Congregate Living Setting Operators **MUST** BE contacted as soon as a staff or child shows symptoms of COVID-19 for additional guidance and decision-making.

Transmission

COVID-19 is spread mainly by coughing, sneezing or direct contact with a person who has the infection or with surfaces they have recently touched. COVID-19 can also be spread when droplets (like from a cough or a sneeze) land on a surface and then someone touches that surface. If that person puts their hands near their mouth, nose or eyes, the person may get the infected with the virus.

Risks

We anticipate the risk to Albertans will increase in the coming weeks. There is a higher risk for people who develop fever and/or cough or shortness of breath AND have travelled anywhere outside of Canada in the 14 days before illness onset or had close contact with a confirmed or probable case of COVID-19 or laboratory exposure known to contain COVID-19 virus.

The health system is committed to work with service providers to ensure the safety of clients, staff and volunteers. They are carefully monitoring the situation and have taken the necessary steps to identify cases and help prevent the ongoing spread of the virus.

Prevention

Agencies and service providers are reviewing, updating and implementing their emergency operating plans and deliberating critical operational decisions. However, it is also important to remember that effective strategies to reduce the spread of COVID-19 by children, staff and volunteers build on everyday infectious disease prevention practices and strategies:

- wash hands every 30 minutes;
- appropriately cover coughs and sneezes with a disposable tissue or your elbow; and
- avoid touching face with hands.

General Prevention

There are many things you can do to prevent the spread of COVID-19 in your facility, particularly by facilitating hand hygiene, respiratory etiquette (covering your cough or sneeze) and physical distancing. Ensure there are enough supplies on hand for proper hand hygiene, including soap, warm running water and paper towels or hot air dryers. Ensure regular environmental cleaning (see general environmental cleaning below).

If possible, consider adding hand sanitizer stations to supplement hand-washing. Use alcohol-based hand rub (ABHR) with greater than 60% alcohol. It is recognized that staff may have concerns with providing free access to ABHR; to address this concern, staff may choose to apply the ABHR directly to children's hands.

Provide tissues and garbage bins for use by staff and children. No-touch garbage cans are preferred for disposal of items.

Remind children, staff and volunteers of the importance of hand hygiene and respiratory etiquette and encourage them to avoid touching eyes, nose and mouth.

Post signage throughout your facility. Examples of posters that can be posted:

- **Help Prevent the Spread**
- **How to Hand wash**

- Cover Your Cough
- Alcohol-Based Hand Rub

Keep at a minimum, of about 2 metres (6 feet) between beds with “head to foot” placement. If possible, in your space, increase the distance between beds even further.

Any group activities that cannot be done within physical distancing guidelines should be cancelled immediately. If you continue to hold activities for children, reduce the size of the activity to **5** or fewer children, strictly monitor for physical distance, personal hygiene, and conduct frequent environmental cleaning and disinfection of the areas used. If cancelling group activities, consider other options for children’s psychosocial benefit.

Encourage all staff and volunteers to get the seasonal flu shot. While this will not prevent COVID- 19, reducing cases of influenza will lessen the burden of illness and the overall concern of symptomatic individuals in the facility.

HUMAN RESOURCES

All workplaces should develop alternate human resource policies for a pandemic emergency to address the following issues:

Attendance Management

During a pandemic, AHS will advise ill people to stay home. Current policies that may pose a barrier to effective disease control and prevention should be suspended or revised as appropriate.

Emergency Scheduling

During a pandemic, work schedules may have to be changed. In planning for these changes, agencies must consider the implications of:

- shift changes
- staff ratio
- changes to hours of work
- compensation and scheduling of overtime
- the need to assign the most qualified employees to specific tasks
- training employees for newly assigned work
- provision of food to employees
- parking requirements or reimbursement for transportation expenses
- scheduling of breaks

Collective agreements, if applicable, may not adequately address these issues. Agencies should negotiate solutions to these issues with each relevant union, where applicable, so that emergency response plans can be implemented effectively and efficiently.

Staff and Operator Disclosure

Staff must immediately tell their supervisor, at any site where that staff member works, if any of the following applies:

- If they have worked at or are working at a site where there is a confirmed COVID-19 outbreak
- If they have symptoms, been exposed to any individual with suspected, probable or confirmed COVID-19 (including if a close or household contact has been told to self-isolate, but has not been offered COVID-19 testing), or
- If they have been tested for COVID-19 within the previous two weeks

This disclosure is mandatory and cannot be used by an operator as the sole reason to dismiss staff. However, the staff may be subject to work restrictions, depending on exposure and a risk assessment.

Reporting of a COVID-19 Positive Staff

Reporting of a COVID positive staff in a facility needs to be done by the agency through their designated contract person. Please note:

- The staff person's name is not required.
- Caseworkers do not have to be informed unless a child or youth has been impacted. If a child or youth is impacted the caseworker, or delegated worker afterhours through NACIS or SACIS, is to be contacted directly and informed through a critical incident report.

It is the responsibility of the designated contract manager or specialist to complete the Covid 19 Reporting Template and forward to the CS-CI-COVID-19@gov.ab.ca mailbox. Positive staff cases will be monitored and tracked by the Office of the Statutory Director.

Deployment of Staff and Resources

It is required that all staff work in a single facility when they have worked in a facility with a confirmed case of COVID-19. Staff are not required to only work in a single facility when there is a site is under investigation. A **"site under investigation"** or **"site under COVID-19 investigation"** denotes a possible outbreak status.

Staff will be encouraged and supported by employers to limit movement and working between facilities where and when possible.

In the case of a **confirmed** COVID-19 outbreak, operators must:

- Identify essential care and services and postpone non-urgent care and services depending on the scope of the potential or confirmed outbreak.
- Authorize and deploy additional resources to manage a confirmed outbreak, as needed, to provide safe client care and services as well as a safe workplace for staff.
- Assign staff in cohort groups to the greatest extent possible.
    - Staff cohort groups should either:

        - Exclusively provide care/service for children that are asymptomatic (no illness or symptoms of illness), or
        - Exclusively provide care/services for children who are symptomatic (have suspected or confirmed COVID-19).
- When cohorting of staff is not possible:
    - Minimize movement of staff between children who are asymptomatic and those who are symptomatic, and
    - Have staff complete work with asymptomatic children (or tasks done in their rooms) first before moving to those children who are symptomatic
- Require staff members work exclusively at one site.
- Deploy other resources, which may include staff who do not normally work in the newly assigned area (ex. Assisting with meals and personal support/care), to assist.
    - An operator must ensure that deployed staff are provided with appropriate training before the task is delegated to them and that appropriate supervision is provided, if needed.
- Unless otherwise directed by AHS Coordinated COVID-19 Response personnel or other responding public health staff, **continue to provide care and support for the symptomatic child within the facility** when possible, given the seriousness of the presenting symptoms.
- All staff are required to work to their full scope of practice to support the children.

No new intakes (placements) to be accepted when a facility has a confirmed case.

However, consideration of new intakes (placements) can occur with a site under COVID-19 investigation for outbreak.

If a youth is waiting for testing results a receiving facility would also use discretion not to admit until results of testing received.

Surveillance for Symptoms in Staff

All staff (including administrators, health care personnel, cleaning staff, food handlers and volunteers) must complete a health assessment screening (Appendix 1) each time they enter/re-enter the facility. If staff have a fever AND/OR answer YES to any screening question, they may not enter the facility. They must notify their supervisor, immediately go home to self-isolate and remain off work for 10 days or until symptoms resolve, whichever is **longer**, or as per direction of the MOH. (See note on testing below).

If illness onset occurs at work, staff must immediately inform the supervisor, leave the facility and self-isolate as above. If the staff member uses public transit, operator will send staff home via taxi with PPE.

AHS Coordinated COVID-19 Response Line for Congregate Living Setting Operators MUST BE contacted as soon as a staff or child shows symptoms of COVID-19 for additional guidance and decision-making. Staff are to identify themselves as group care staff when speaking to AHS.

Effective March 12, all Albertans with symptoms, even if they have not travelled, are asked to stay home until 10 days have passed from the start of their symptoms. This may impact staffing levels, but is a precaution to prevent spread of illness in the community. (See note on testing below).

Note: Testing has been expanded and made available to staff. Staff who have been tested for COVID-19 and have received a negative result may return to work once symptoms are no longer present or as directed by AHS.

Staff Just Returning from Travelling From Outside of Canada

Effective March 12, all Albertans currently outside Canada are required to self-isolate for 14 days when they return. Self-isolation guidance can be found **here**.

Staff can stay up to date on current recommendations for travelers **here**.

Please visit the following websites if you have further general questions about what COVID-19 is, how it is spread, or how many cases there are in the world at present.

- **Alberta Health**
- **Alberta Health Services (AHS)**
- **Public Health Agency of Canada**
- **World Health Organization**

Occupational Health and Safety

A pandemic will likely cause a high level of fear and anxiety among the general population. Employees will be concerned about their own health and the health of their families. They may be concerned about potential exposure to COVID-19 in the workplace and, as a result of these concerns, some may refuse to work. Employees will have questions relating to occupational health and safety. Informing employees of their rights, providing training and equipment as appropriate, and communicating openly about emergency planning processes will help to alleviate anxiety. Click **here** to see more Information Regarding Right to Refuse Dangerous Work.

Psychosocial Support

People affected by a disaster, such as a pandemic, must adjust to major changes in their lives. People may be grieving for friends or family members and may have to deal with personal or family crises. Many people will need to talk about their feelings and experiences and learn how to face the challenges of an unknown future.

All agencies should develop strategies to increase psychosocial support for both employees and children and youth during a pandemic.

GUIDANCE FOR SERVICE PROVIDERS

As of April 28, 2020, a CMOH Order (14-2020) limits visitors to congregate care facilities to essential visitors only. Essential visitors are defined as:

- Individuals over the age of 18 who are designated by the resident to provide care to meet the needs of the resident that would otherwise be unmet.

All visits by an essential visitor must be pre-arranged with the staff of the facility in advance. In addition the visitor must:

- be escorted at all times, and
- wear a face covering or mask that covers their mouth and nose while in attendance in the facility.

All visits must be recorded, including the individual's name, date and time.

All children, staff and essential visitors must be screened prior to being allowed entry into a facility using the Health Assessment Screening tool (Appendix 1).

As Children's Services phased approach to resuming legislative responsibilities takes place the definition of "essential visitors" has expanded to include caseworkers, those involved in family visits and individuals with whom the child or youth has a significant connection.

Staff must wash their hands every 30 minutes with soap and warm water. This includes when they first arrive at the facility, before preparing food, after any contact with saliva or nasal secretions (e.g., used tissues), after handling children's belongings, after cleaning activities, and after using the washroom. Refer to hand-washing guidance **here**.

Staff should avoid touching eyes, nose, mouth and face, and should remind each other if they see co-workers touching their own faces.

Cover coughs and sneezes and then wash hands. Refer to respiratory etiquette guidance here:
Routine Practices
Point of care Risk Assessment

People living and working within the facility **do not** need to wear or use any additional PPE, unless they are in a situation where they or someone else is displaying or reporting symptoms of illness.

Staff working multiple sites must ensure they are changing into clean clothes **prior** to entering a new facility.

If using disposable gloves for any tasks, hand-washing is still important and should be done before putting on and after removing the gloves. If using gloves, change often, especially if soiled, ripped or become dirty.

Perform daily symptom checks for children and look for changes in usual behavior, especially if the child is non-verbal. Ensure that children are aware that they are to immediately notify staff if they are

feeling unwell. If a child exhibits symptoms, they must be isolated immediately, taken to their room, or to an available isolation room, while following proper procedure and having the child or youth wear a surgical mask.
Immediately contact the COVID-19 Coordinated Response Line for Congregate Living Setting Operators 1-844-343-0971.

New Residents

New residents are not required to use a mask unless the answer to any of the screening questions is "yes". If the answer is "yes" the new resident should be tested.

When completing an intake consultation with the caseworker and previous placement should occur to determine health and any information that would assist while assessing the youth during screening.

Facilities may use discretion in implementing additional precautions based on the circumstances surrounding the placement, including information from previous placement or resident of the youth.

Additional precautions, at the facilities discretion, may include: requiring the youth to wear a mask for a period of 48 hours, assigning the youth their own room, their own bathroom (where available) or increased physical space (where able).

Physical Distancing in the Workplace

During a pandemic, the more people you are in contact with, the more you are at risk of coming in contact with someone who is infected. Physical distancing means reducing or avoiding contact with other people as much as possible. Some workplace strategies to achieve this may include:

- Minimizing contact with others by using stairs instead of crowded elevators;
- Canceling non-essential face to-face meetings and using teleconferencing, e-mails, and face-time instead; staying two metres (six feet) away from others when a meeting is necessary
- Avoiding shaking hands, hugging, or kissing people
- Bringing lunch and eating at your desk or away from others

Food Handling

Germs from symptomatic children/staff (or from contaminated surfaces) can be transferred to food or serving utensils. Facilities should reinforce routine food safety and sanitation practices. Where possible, implement measures to minimize child handling of shared food and items that may touch another child's food, such as:

- Dispense food onto plates for children
- Minimize child handling of multiple sets of cutlery
- Remove shared food containers from dining areas (e.g. shared pitchers of water, shared coffee cream dispensers, salt & pepper shakers, etc.)
- Dispense snacks directly to children and use pre-packaged snacks only
- Ensure that food handling staff are in good health and practice good hand hygiene

- Ensure that all surfaces of the tables and chairs (including the underneath edge of the chair seat) are cleaned and disinfected after each meal
- Staff assigned to housekeeping duties should not be involved in food preparation or food service, if possible

General Environmental Cleaning

- Have additional cleaning supplies on hand.
- CAVI Wipes are good disinfectant wipes.
- Increase frequency of cleaning and disinfecting on "high touch" surfaces to a minimum of three times daily. High touch surfaces include door knobs, light switches, railing, tables, chairs etc.
- Cleaning and disinfecting on "low touch" surfaces completed at least once per day. Use a disinfectant that has a Drug Identification Number (DIN) and a virucidal claim. Be sure to follow the instructions on the label to disinfect effectively. Alternatively, you can prepare a bleach water solution with 100 ml of unscented household bleach per 900 ml of water.
- Be sure to use take the appropriate precautions when using chemicals for cleaning and disinfecting. Consult the products' Safety Data Sheets.
- Consider all surfaces in the child's environment as contaminated. Start at the cleanest part of the equipment or surface and move towards the dirtiest.
- Ensure manufacturer recommended wet-contact time is achieved. Wet contact time is the minimum time required for items to be in contact with the disinfectant to ensure germs are killed.
- Place equipment on a clean surface to air dry. Do not actively dry with a towel or other device.
- Store all disinfectants out of the reach of children, pets and confused individuals.
- Clean child care areas on a regularly scheduled and frequent basis.
- Clean and disinfect all non-critical equipment and environmental surfaces between child use (e.g. shared equipment, treatment surfaces such as mats, platforms and tables)
- Clean and disinfect sleeping mats after every use.
- Wash children's bedding frequently.
- Use care when handling laundry: have a system to keep dirty laundry separate from clean laundry.
- Staff or volunteers doing cleaning, including handling laundry, should wear gloves and gowns. The labels of the cleaning and disinfecting products you are using will likely identify what protective equipment staff or volunteers should use.
- Remove or discard communal products (ex. shampoo, creams); children must have their own personal products.

PLANNING FOR A POTENTIAL OUTBREAK

Under Investigation and Confirmed COVID-19 Outbreak Standards

CMOH orders utilize the term "under Investigation" and refers to under investigation for a COVID-19 outbreak and is not to be confused with a facility investigation under CYFEA.

The standards set expectations for any facility that is under investigation or confirmed for a COVID-19 outbreak.

1. A *under investigation for a* ***COVID-19 outbreak*** is defined as:
    a. At least one resident or staff member who exhibit **any** of the symptoms of COVID-19.

2. A *confirmed* ***COVID-19 outbreak*** is defined as:
    a. Any one individual (resident or staff) laboratory confirmed to have COVID-19.

Start planning now to reduce the impact of a potential outbreak in your facility. Here are some steps to take in advance:

- Consider connecting with other providers of similar services, municipalities, and AHS Zone Public Health and make a list of key contacts (see Appendix 2 for AHS Zone Public Health Contacts).
- Analyze the capabilities of your facility. Do you have separate spaces for symptomatic children or those who need to self-isolate? If not, are you aware of alternate locations? Make a list of nearby healthcare and housing facilities that may need to be used for the children.
- Screen staff and children and any essential visitors prior to allowing entry into the facility, **including youth returning from AWOL** by using the Health Assessment Screening tool (Appendix 1).
- Identify contingency plans for increased staff and volunteer absenteeism. You might consider cross-training current staff, or hiring temporary staff. More information on business continuity can be found **here**.
- If you have a healthcare facility onsite, ensure the facility and staff are prepared. Information for health care providers can be found **here**.
- Be aware that you may need to order additional operational supplies like food, toiletries, and arrange for additional staffing.
- Have a communication plan. How will you get information to staff, children, volunteers, community partners, and other key stakeholders in a timely manner? Consider internal websites, email strings, automated text messaging, etc.
- Be aware that everyone may be at risk for adverse mental health outcomes during a stressful event like a disease outbreak. How can your organization support both staff and children?
- Stay informed about the local COVID-19 situation, using trusted resources such the links to Alberta Health and Alberta Health Services included in this document.
- A Group Care Case Scenario has been attached to this guide as a reference, see Appendix 3.

RESPONDING TO A SICK CHILD OR YOUTH

Staff Responsibilities

AHS Coordinated COVID-19 Response (1-844-343-0971) is available to all congregate settings. They **must be contacted as soon as there is a person showing symptoms of COVID-19** for additional

guidance and decision-making support. **This applies to a site under COVID-19 investigation or a confirmed outbreak**.

With any level of COVID-19 outbreak, the individual with symptoms must be promptly isolated. The AHS Coordinated COVID-19 Response personnel, as indicated by their protocols, will arrange testing of the child or youth for COVID-19.

Operators must review and implement the *AHS Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites.*

Ensure to notify the child's case team, or the after-hours office when a child presents with symptoms.

The following information will act as a guide for staff supporting children who have developed symptoms. It is essential that each child who has these symptoms be isolated to their individual bedroom and follow recommendations from the COVID-19 Coordinated Response Line for Congregate Living Setting Operators – 1-844-343-0971.

- Provide a facemask right away to any child exhibiting respiratory symptoms such as fever, cough, sore throat, shortness of breath, additional respiratory symptoms, muscle aches or extreme tiredness.
- Symptomatic children should be isolated using **contact and droplet precautions**.
- Symptomatic children should be confined to their rooms with their meals served to them in their room. If this is not practical, restrict to their own unit.
- Everyone in the facility, including the symptomatic child should perform hand hygiene regularly.
- Practice good respiratory etiquette followed by hand hygiene.
- Limit the number of caregivers. Caregiving within 2 meters of the symptomatic child should be limited to one person.
- PPE will be needed for those staff providing care to all isolated children (symptomatic or asymptomatic; whether the infection is under investigation or confirmed) and as advised by public health.
- Staff who are following handwashing guidelines, using appropriate PPE and applying it correctly while caring for children with suspected or confirmed COVID-19, are not considered "exposed" and may safely enter public spaces or other rooms within the facility.
- Any individual (child or staff) who has had direct contact with a person who is confirmed for COVID-19, without wearing recommended PPE, is required to self-isolate as per the CMOH direction.
- Place signage inside the symptomatic child's room, near the door, alerting other staff and children that child is symptomatic and precautions are required.
- Prevent exposure to contaminated items and surfaces. Do not use personal items that belong to the child such as toothbrushes, towels, washcloths, bed linen, unwashed eating utensils, drinks, phones, computers, or other electronic devices. The lid of the toilet should be down before flushing to prevent contamination of the environment.

- Frequent cleaning and disinfecting. High-touch areas such as toilets, bedside tables and door handles should be disinfected daily using a store bought disinfectant, or if not available, a diluted bleach solution (0.5% sodium hypochlorite).
- Disposing of waste. All used disposable contaminated items should be placed in a lined container before disposing of them with other household waste.
- Use precautions when doing laundry. Contaminated laundry should be placed into a laundry bag or basket with a plastic liner and should not be shaken. Gloves and a medical or procedural mask should be worn when in direct contact with contaminated laundry.
- Clothing and linens belonging to the symptomatic child can be washed together with other laundry, using regular laundry soap and hot water (60-90°C). Laundry should be thoroughly dried.
- Hand hygiene should be performed after handling contaminated laundry.
- If the laundry container comes in contact with contaminated laundry, it can be disinfected using a store bought disinfectant, or if not available, a diluted bleach solution (0.5% sodium hypochlorite).
- If household members have direct contact with the symptomatic child, they should wear a medical or procedural mask and eye protection when within two meters and should perform hand hygiene after contact.
- Caregivers should wear disposable gloves when in direct contact with the symptomatic child, or when in direct contact with the child's environment as well as soiled materials and surfaces.
- Hand hygiene should be performed before putting gloves on and after removing them.
- Ensure children and staff remain well informed so that proper precautions, planning and actions can be taken.
- Operators will notify all staff if there is a suspected outbreak at the site. Operators will identify the best way to communicate (ex. letters, email, posters, website, etc.). If the outbreak is "under investigation" or "confirmed", operators will also notify all children in the facility.
- Note that if test results for the symptomatic child or staff are negative for COVID-19, usual influenza-like-illness or gastrointestinal illness outbreak protocols should be followed, as appropriate to the identified organise causing the outbreak.
- The operator may need to put special measures in place, working with public health, to help enable the isolation for children who are not able to understand their own restrictions (ex. If the person has cognitive impairment).
- **New placements should not occur if there is an under investigationor confirmed outbreak, unless at the direction of the CMOH**.

Severe Symptoms:

If the child is experiencing the following conditions, staff need to call 911 **immediately**, advise dispatcher and any medical teams who arrive that symptoms are consistent with COVID-19. Update the case team.

- Shortness of breath

- Increase in chest pain with breathing
- High Fever over 39/100 that does not respond to medication
- Laboured breathing
- No fluid intake in 24 hours
- Decrease in consciousness/responsiveness
- Any discoloring of lips, face, finger tips
- Extreme vomiting/diarrhea
- Any signs of confusion/disorientation

INFORMATION ON SELF-ISOLATION

Self- isolation is very important in preventing COVID-19 from spreading to others. A **Self-Isolation Information Sheet** has been developed by Alberta Health and may be helpful to staff in providing children and youth answers to their questions.

- Isolate child immediately, following proper procedure and having child wear a surgical mask.
- Place child in an individual room with four walls and a door, if possible.
- If individual rooms are not available, consider using a large, well-ventilated room.
- Space beds apart as much as possible (2 metres or greater), have children sleep head-to-toe, and put up temporary barriers between beds, such as plastic sheeting.
- If possible, designate specific washrooms for symptomatic children only.

If a child is refusing to self-isolate when they are presenting with symptoms or have a confirmed case of COVID-19, contact the caseworker or the after-hours office for further direction.

More information on Self-Isolation can be can be found at **here.**

Supplies Needed For Isolating

- Medical or procedural masks for child and others in the home
- Disposable Gloves
- Eye protection
- Thermometer
- Fever-reducing medications
- Running water
- Hand soap
- Alcohol based hand sanitizer (ABHS) containing at least 60% alcohol
- Tissues
- Waste container with plastic liner
- Regular household cleaning products
- Store bought disinfectant, or if not available, bleach and a separate container for dilution.
- Alcohol (70%) prep wipes

- Regular laundry soap
- Dish soap
- Disposable paper towels

Given the high demand for supplies, specifically Personal Protective Equipment, ensure to use them as required and/or directed by AHS to avoid unnecessary use and waste.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Personal Protective Equipment (PPE) is a key element in preventing the transmission of disease. To ensure an ongoing supply of PPE, they should only be used when necessary. Also, if not used properly, not only will PPE fail to prevent transmission, it may in fact contribute to the spread of disease. For more information on when and how to use PPE, click **here.**

Putting on and Removing PPE

Alberta Health Services has provided the following video demonstrating how to safely put on and remove PPE when required.

Video: Donning and Doffing of PPE

Gloves

Disposable single use gloves should be worn when in direct contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids, including dishes, cutlery, clothing, laundry, and waste for disposal. Gloves are not a substitute for hand hygiene; caregivers must perform hand hygiene before and after putting on and taking off gloves.
Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled during care.

- To remove gloves safely, with one of your gloved hands pull off your glove for the opposite hand from the fingertips, as you are pulling, form your glove into a ball within the palm of your gloved hand. To remove your other glove, slide your ungloved hand in under the glove at the wrist and gently roll inside out, and away from your body. Avoid touching the outside of the gloves with your bare hands.
- Gloves must be changed and hand hygiene performed when they are torn.
- Discard the gloves in a plastic-lined waste container.
- Perform hand hygiene.
- Double-gloving is not necessary.
- Reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use with a store bought disinfectant, or if not available, a diluted bleach solution (0.5% sodium hypochlorite).

Eye Protection

Eye protection is recommended to protect the mucous membranes of the eyes when caring for an ill child or a suspected case throughout any activities likely to generate splashes or sprays of body fluids including respiratory secretions.

- Eye protection should be worn over prescription eyeglasses. Prescription eyeglasses alone are not adequate protection against respiratory droplets.
- Protective eye wear should be put on after putting on a mask.
- After applying eye protection, gloves should be donned (see above).
- To remove eye protection, first remove gloves and perform hand hygiene. Then remove the eye protection by handling the arms of goggles or sides or back of face shield. The front of the goggles or face shield is considered contaminated.
- Discard the eye protection into a plastic lined waste container. If the eye protection is not intended for single use, clean it with soap and water and then disinfect it with a store bought disinfectant , or if not available, a diluted bleach solution (0.5% sodium hypochlorite), being mindful not to contaminate the environment with the eye protection.
- Perform hand hygiene.

Mask

Wear procedure/surgical mask for any encounter, within two metres, with a child who has or is suspected of having COVID-19. This includes a child displaying or reporting symptoms of illness.

Workers providing direct resident care are not required to continuously mask. The use of physical distancing, responsible use of masking and other precautions as necessary should continue.

Gown

Use for any direct contact of clothing or forearms with child or child's environment.

Access to PPE

This is the Provincial Emergency Social Services Emergency Coordination Center's NEW PPE procurement process.

For more information on the appropriate PPE required for your organization's environment, please review the **Alberta Health Services best practices** on PPE use.

1. Each Agency must review their existing PPE inventory and continue to source PPE materials through local sources as best as possible. If you have a URGENT need now and you have exhausted all other resources please contact ALIGN at **nicolem@alignab.ca**.
2. When an Agency is running low on PPE supplies, they can submit their PPE requests using the following website: **https://ppe.sp.alberta.ca/Lists/Requests/New.aspx?IsDlg=1**

To assist triaging the requests, please ensure to indicate the following:

- In the "Agency Type" drop-down choose "Group Home/Residential (Child Intervention)"
- In the "Other/Comment" section add:
- Your PPE is at critical or urgent level (see below for definition)
- Staff to client ratio
- A request for N95 masks would requires confirmation from Infection/Protection as per the' Integrated guidelines for the distribution of PPE, sanitization and hygiene products during Covid-19'.
- Any other important information
- Ensure that your order is for no more than 14 days

Note: Not all requested PPE materials may be supplied

There is an attempt to process and fill orders as quickly as possible and organizations may receive partial shipments, as supplies are sent out as soon as they come in. Organizations should keep track of their various packing slips to ensure all requested items are received.

Definitions:

- Critical – You only have enough PPE to last 24 hrs
- Urgent – You only have enough PPE to last 48 hrs.
- Vital – You only have enough PPE to last 72 hrs.

Consolidated information regarding PPE's in one document can be found here as well as the ALIGN Communication page.

FURTHER INFORMATION

Up-to-date information on the evolving situation of COVID-19 in Alberta and Canada is available on the following websites:

- **Alberta Health (COVID-19 Info for Albertans)**
- **Alberta Health Services (Novel Coronavirus COVID-19)**
- **Public Health Agency of Canada (COVID-19: Being Prepared)**

APPENDIX 1: HEALTH ASSESSMENT SCREENING TOOL

All persons entering the facility must be screened every time they enter the facility.

Screening shall involve both of the following:

1. **Temperature Screening:**
   - Temperature must be taken by a non-invasive infrared or similar device (oral thermometers must not be used).
   - Anyone with a temperature of 38.0C or higher MUST NOT be admitted to the facility.

2. **COVID-19 Questionnaire:**

1.	Do you have any of the below symptoms:		
	Fever	YES	NO
	Cough	YES	NO
	Shortness of Breath/Difficulty Breathing	YES	NO
	Sore Throat	YES	NO
	Runny Nose	YES	NO
	Feeling Unwell/Fatigued	YES	NO
	Nausea/Vomiting/Diarrhea	YES	NO
2.	Have you, or anyone in your household travelled outside of Canada in the last 14 days?	YES	NO
3.	Have you had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with cough and/or fever?	YES	NO
4.	Have you, or anyone in your household been in contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?	YES	NO

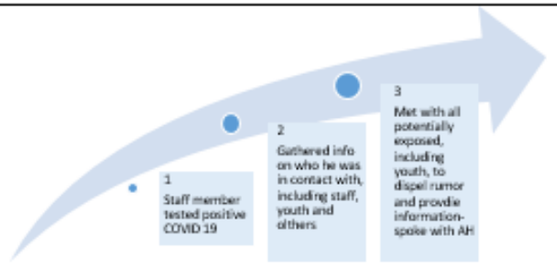
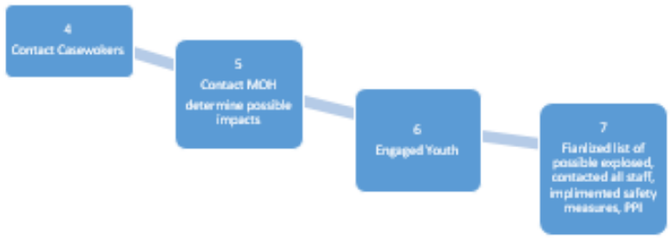
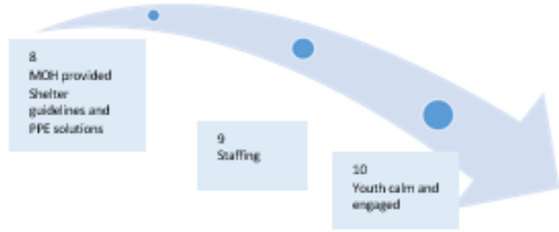
If staff or an essential visitor answers YES to any of the questions, the individual MUST NOT be admitted to the facility and should be advised to leave the building in order to protect the health of the residents.

If a youth in residence answers YES to any of the above questions, have the youth self-isolate, take proper precautions AHS.

APPENDIX 2: AHS ZONE PUBLIC HEALTH CONTACTS

AHS ZONE (Link to Zone MOH)	REGULAR HOURS Business hours may vary slightly from Zone to Zone, but are typically 8:30 am – 4:30 pm			AFTER HOURS
Zone 1 South	Communicable Disease Control	CDC Intake	587-220-5753	(403) 388-6111 Chinook Regional Hospital Switchboard
	Environmental Public Health	EPH CDC Lead	403-388-6689	1-844-388-6691
Zone 2 Calgary	Communicable Disease Control	CDC Intake	403-955-6750	(403) 264-5615 MOH On-Call
	Environmental Public Health	EPH Disease Control	403-943-2400	
Zone 3 Central	Communicable Disease Control	CDC Intake	403-356-6420	(403) 391-8027 CDC On-Call
	Environmental Public Health	24 Hour Intake	1-866-654-7890	1-866-654-7890
Zone 4 Edmonton	Communicable Disease Control	CDC Intake Pager	780-445-7226	(780) 433-3940 MOH On-Call
	Environmental Public Health	EPH		
Zone 5 North	Communicable Disease Control	CDC Intake	1-855-513-7530	1-800-732-8981 Public Health On-Call
	Environmental Public Health	EPH		

APPENDIX 3: GROUP CARE CASE SCENARIO

		
#1 March 16- evening Facility (ABC facility) employee tests positive for COVID-19. Regional Director (RD) contacts Statutory Director (SD) and facility calls 811 / Alberta Health (AH) **#2** Gathered information regarding youth and staff who were potentially exposed. **#3** Met with the youth and staff to keep them informed and de-escalated. We provided them daily updates thereafter. Provided list of staff / youth who were potentially exposed during timeframe agreed upon with AH. Anyone with symptoms was to isolate. Locked facility to public. Contacted Agency.	**#4 March 17** Contacted all caseworkers, provided info and asked that they begin looking at options for access. Began staffing contingency planning. Regional zoom session to update all staff, and alleviate gossip. **#5** Call with Medical Officer of Health, and discussed the challenges of isolating all staff and youth. MOH will consult and return call. Personal Protective Equipment audit and procurement. **#6** Youth engaged in sanitizing their rooms / living area. Discussed importance of avoiding exposure. Provided alternatives for smokers, and arranged for activities. **#7** Ongoing calls to and from dedicated MOH. All exposed employees and youth contacted and directed to isolate. This affected all but three employees. Implemented contingency staffing measures	**#8 March 19** MOH provided guidelines/measures for Shelters and sent a Heath Inspector to attend the facility. PPE (gowns, masks, gloves) to be supplied and provided posters/information etc. Chief MOH – Calgary called to ask the facility continue to monitor for symptoms and exercise universal precautions. Keep kids in but not “isolated” until the period identified for exposed staff. Facility contacted local hospital, who agreed to provide PPE for emergency situations. Health Inspector provided in-service on how to safety put on and remove PPE. **#9** Staffing schedule complete, and management are relieved of redeployment duties **#10** Youth were engaged throughout the process. This allowed them to be active participants, be solution focused, and they were treated with transparency and respect.

COVID-19 Placement Resource Practice Guidance: Process to Meet Urgent COVID-Related Placement Needs

RESPONSE AND SUPPORT TO ENSURE SAFE PLACEMENT OF YOUTH WHO ARE IMPACTED BY COVID RELATED ISOLATION REQUIREMENTS

Children's Services (CS) and their contracted service providers are committed to meet the needs of all children and youth in care. At this time, that care is to be delivered, balancing the requirement to comply with the Chief Medical Officer's recommendations on managing COVID19 in order to keep children, youth, staff and agency staff safe.

The needs and the behaviours displayed by a small number of youth in care are challenging and complex. Those needs and behaviors are not new, and we have processes in place to guide us through the management of those behaviours in a supportive and trauma informed way.

The environmental circumstance presented by the COVID-19 Pandemic *is* new. It has increased social anxiety and this worry may intensify the behaviors demonstrated by children and youth as well as amplify our perception of these behaviors. We must rely on our practice principles as the foundation for how we approach this new reality.

Our Commitment

During the pandemic and CS focus on essential services, one of our priorities is supporting care providers. Below is the process for supporting group, therapeutic campus based and congregate care settings. For care providers delivering service during this time, in addition to the child's case team, your contract specialist is also available to support and assist you.

Objective

Provide a scaled approach to support children and youth receiving services under the Child Youth and Family Enhancement Act who are unable, unwilling or those who are willing, however, can not be isolated in their current location and need alternative accommodations. These actions are developed with a view to adhering to the Chief Medical Officer of Health's (CMOH) directives on isolation and for slowing the spread of COVID-19 while protecting the health and safety of Albertans.

Laddered Approach to supporting youth to comply with COVID-19 guidelines

Each facility is required to have a pandemic plan as per their business continuity plan (BCP), which encompasses the safe provision of care to a youth who is required to isolate, is symptomatic or has tested positive for COVID-19. Once a youth presents with symptoms, the facility must immediately follow isolation guidelines and contact AHS Coordinated COVID-19 Response (1-844-343-0971) for direction and follow-up, even if the youth continues to AWOL.

COVID-19 Placement Resource Practice Guidance: Process to Meet Urgent COVID-Related Placement Needs

More information can be found in the Practice Guidance for Service Providers in Supported Independent Living, Group and Congregate Care in Alberta.

CS and Agency staff should ensure all youth in group care settings understand the COVID-19 guidelines including the risks and consequences of not following them.

First option of choice is to increase supports and employ all efforts to maintain the youth in the current placement. Such efforts would include but is not limited to: one to one support, increased staffing, or additional facility cleaning.

Second option of choice If a youth repeatedly AWOLs the case team, which includes the caseworker and agency staff, will assess whom they are running to, considering the viability of safely maintaining them with their extended family/kinship, cultural kinship or community connections. In such cases, using a harm reduction lens, the case team can assess if a safety plan to support them elsewhere is reasonable, safe and appropriate.

Determine if an alternate placement will better meet the needs of the youth at this time.

Follow policy and practice supports when making decisions, include case team manager where necessary and utilize a third party consult if required.

Third option of choice If, after all reasonable attempts to support a youth safely in their placement have been made, no other options have been identified and the youth poses a risk to other youth and staff,
OR
If, the facility is nearing critical failure, meaning it is unable to continue to operate under current circumstances:

The case team, including agency staff, will escalate the matter to the Category 4/Associate Director. Once this has been escalated to a Category 4/Associate Director ***ensure the agency is informed the matter has been escalated, provide an approximate timeline for follow up and develop a plan for ongoing communication.***

If, following the Category 4 consultation, it is concluded that all reasonable measures have been exhausted and that the youth poses a risk to public health, then a delegated staff will be assigned to contact the Medical Officer of Health (MOH) to advise that there is a youth who is noncompliant with COVID-19 isolation requirements.

- The MOH will provide advice which will assist in determining next steps and may include:

COVID-19 Placement Resource Practice Guidance: Process to Meet Urgent COVID-Related Placement Needs

  - A Medical Officer of Health making an order under the Public Health Act to apprehend, convey and detain people who are not following CMOH orders. Caseworker collaborate with AHS and local police authorities to develop a plan to have the youth transported to the facility.
  - The police may detain the youth under a health order and transport them to a facility for isolation. Any youth detained would not return to placement until it is safe for them to do so or the period of confinement has ended as directed by AHS
  - Isolating due to symptoms/testing positive is a minimum of 10 days from the start of symptoms/positive test, or until symptoms resolve, whichever takes longer
  - If MOH does not deem detention necessary, as the youth may not meet their threshold for non-compliance to a Public Health order, but the youth is unable to return to their placement, the case team will consult a Category 4/Associate Director for further placement assistance.
- If, after review, the Category 4/Associate Director believes that critical failure is imminent or that no other placement options are appropriate, and the youth is COVID impacted the matter is escalated to the Regional Director, who will assist by either accessing a regional "redundancy bed" or may consult with another Regional Director to secure an appropriate placement.

Redundancy beds are for COVID-19 impacted youth. Not limited to but could include: COVID positive, symptomatic and or impacted as a result of other factors such as the need to leave a facility due to lack of staffing or infection rates.

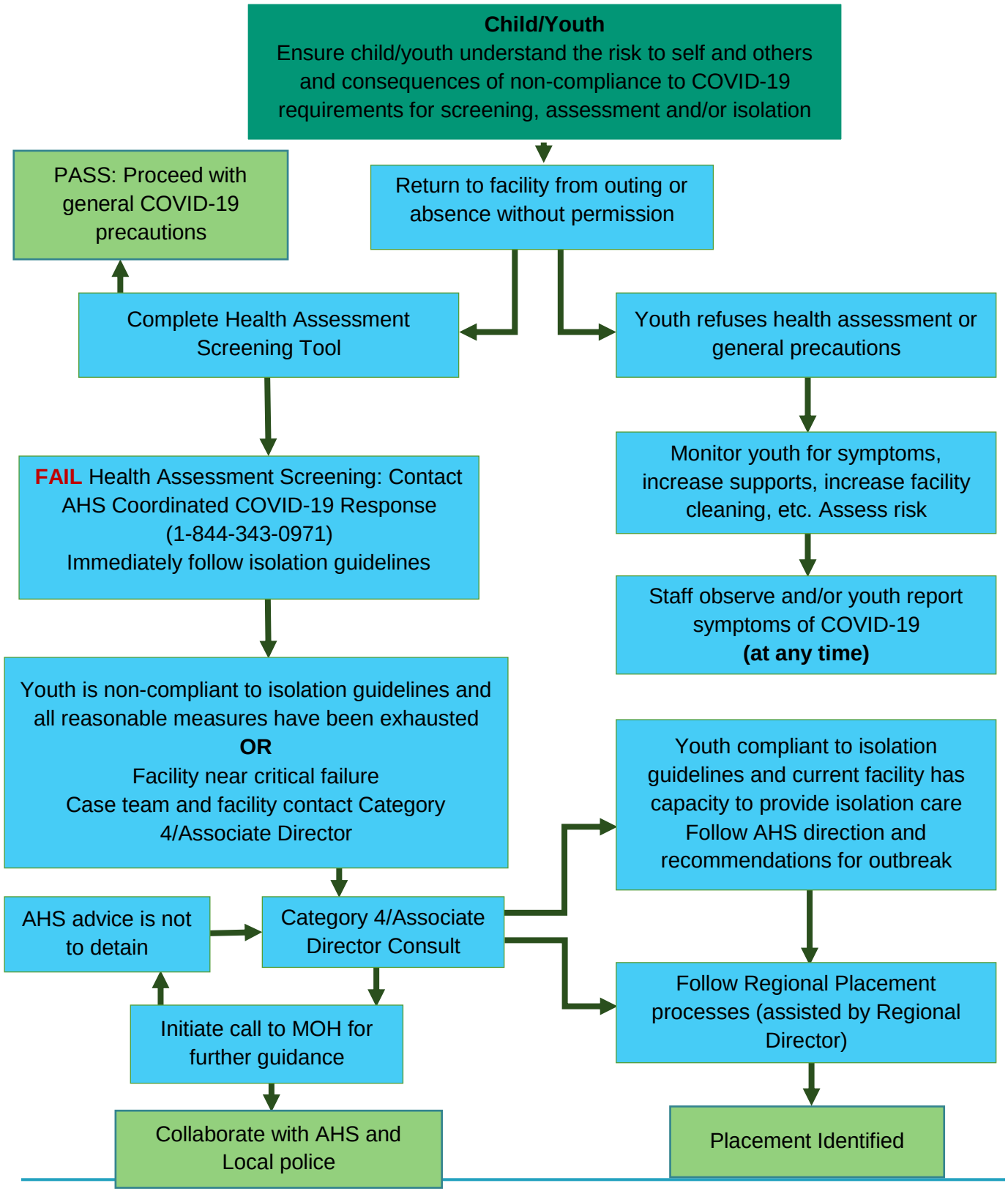
Attachments

Practice Guidance for Service Providers in Supported Independent Living, Group and Congregate Care in Alberta

Practice Guide for Contracted Service Providers

Alberta Health Services COVID-19 Self-Assessment

COVID-19 Placement Resource Practice Guidance: Process to Meet Urgent COVID-Related Placement Needs



Child Intervention Practice Guidance

Coronavirus (COVID-19)

Revised May 04, 2020

Alberta

CI Practice Guidance:

Coronavirus (COVID-19)

UPDATE AS OF 11:00 AM May 04, 2020

UPDATES HIGHLIGHTED

As a legislative service, the Ministry is required to continue to fulfill its obligations under the Child, Youth and Family Enhancement Act, in particular assessing harm and danger and ensuring the well-being of children.

The safety and wellness of all of our staff and children we serve is paramount. As you are aware, the situation in Alberta is evolving rapidly and we are continuing to assess what it means for Child Intervention service delivery.

This Practice Guidance includes information regarding shifts that we are making in our approach to adapt Child Intervention service delivery during the COVID-19 pandemic.

Please note that these instructions will be adapted as Alberta Health's guidance to Albertans evolves. We commit to providing regular updates. All new updates will be listed on this page and highlighted in the relevant sections.

Updates on May 04, 2020:

- Information regarding **Youth Subject to a Medical Officer of Health Order to Isolate** has been added to **Documentation.**
- Additional clarification around instructions for completing the digital IRC form in **Intervention Record Checks**.
- New practice guidance has been developed for **Home Study Reports**.
- **Child and Youth Support Program** has been updated with instructions on payment process for private child care.

This Practice Guidance is designed for easy navigation and quick search for specific topics. To locate information on specific topics, you can use:

- The Table of Contents: By clicking on one of the topics on the Table of Content page, the link will bring up the specific page where the practice guidance of the topic is on.
- The "Bookmarks": By clicking on one of the topics in the Bookmarks from the tool bar, the bookmark will bring up the specific page where the practice guidance of the topic is on.
- The "Search" function: By typing in the search term in the text box on the Find toolbar (Ctrl + F), this will give you all the matched terms in the document.

If you notice any links are broken, please let us know at CS-CI-COVID-19@gov.ab.ca.

Table of Contents

Important Links

Alberta Health COVID-19
MyAPS COVID-19 Response
Alberta Health Services COVID-19 Response

Relevant Forms

COVID-19 Reporting Form
Intervention Record Check
Child Maintenance Invoice

Additional Guidance

Alberta Health Screening Questionnaire
Facilities Practice Guidance

Date Released:	Date Updated:
March 31, 2020	April 22, 2020

ASSESSMENT OF HARM AND DANGER

As Child Intervention (CI) Practitioners, we have an important part to play when CI is providing services to children, youth and families. During the COVID-19 Pandemic, we are taking even more measures to help CI Practitioners stay safe.

The intent of this process is to facilitate critical thinking and to challenge assumptions to ensure that decisions are made based on thorough assessment and analysis, and in the best interests of the child(ren). We need to ensure that any options that may not have been considered are discussed and weighed as potentially protective or preventative to the imminent need identified.

This guidance will assist caseworkers involved in Intake and Assessment to:

- determine the level of response, and
- what the response will look like.

*Use whichever scaling question(s) make the most sense for each situation.

Incidents of Abuse in Alberta

The 2008 Alberta Incidence Study of Reported Child Abuse and Neglect found the majority of reports received are not urgent. It is therefore important for us to slow down and support families rather than react to crisis. The majority (85 per cent) of substantiated investigations fall in the category of non-urgent/other maltreatment related concerns indicating a risk of harm; danger to development or well-being; or the reported concerns were complicating factors rather than abuse or neglect (e.g., poverty in situations of neglect) (Trocmé, Kyte, Sinha, & Fallon, 2014).

Preliminary Screening Scale at Intake or Assessment: Based on what you know about this family situation and everything that has been explored, on a scale of 0-10 where:

- **10** = considering what you know to date, this case is likely in the 85 per cent of our work where we have some worries but the child(ren)/youth is not at risk of being seriously harmed or dying; and
- **0** = considering what you have read, this case represents the 15 per cent (urgent incidents such as, but not limited to physical abuse, sexual abuse, neglect under the age of six, etc.) and the child(ren)/youth is at risk of serious harm and requires a co-ordinated approach with police and/or the child(ren)/youth being interviewed without the parents' knowledge.

What gets you to that number, prevents you from being higher, next steps?

Secondary Screening Scale: If you feel this is an 85 per cent matter (non-urgent concern), on a scale of 0-10 where:

- **10** = given the information you know today, the concerns can be alleviated over the phone or via Skype interviews with all participants; and
- **0** = by calling or requesting phone interviews, we could increase the risk of harm/danger to the child(ren)/youth as they are at home and not visible to others during the COVID-19 outbreak.

Is a call to the family being made to make the CI practitioner feel better with no increased safety to the child(ren)/youth (remember, telling someone to stop a behaviour does not necessarily, in and of itself; increase safety.)? What gets you to that number, prevents you from being higher, next steps?

In cases of family violence, please also ask:
How would you approach the assessment, knowing you cannot see the family in person or know where the alleged perpetrator is, to ensure the risk to the victim and child(ren)/youth is not increased as a result of Children's Services (CS) contact?

Critical Thinking and Scaling Questions

Scaling Question #1
On a scale of 0-10, thinking about all the children, youth and families we have to work with in the midst of isolation and COVID-19, where:

- **10** = this intake definitely includes some worries. It is clear we need to work with this family but the work does not require an immediate CS response. Based on what we know about the harm, danger and existing strengths and safety, we are confident there is a plan/people in place to ensure the child(ren)/youth's immediate safety. We can either conduct our assessment remotely or they can wait for our services; and
- **0** = we have not been able to ensure there is a plan/network in place to keep the child(ren)/youth safe and the harm to the child(ren)/youth was significant. We cannot determine whether there are enough existing strengths or safety, and do not know if there is a network who could help. We are confident seeing the child(ren)/youth in person is the only way to fulfill our legislative responsibilities and keep the child(ren)/youth from being seriously harmed.

Scaling Question #2
On a scale of 0-10, thinking about all of the children, youth and families we have to work with in the midst of isolation and COVID-19, where:

- **10** = if the child(ren)/youth is not seen by me today, they would remain safe in the care of their parents. There would still be worry but the risk of actual harm is low. There are others who can connect with the family (if needed) and there is a safety plan that can be reviewed, refined, or developed over the phone; and
- **0** = if the child(ren)/youth is not seen by me today, the potential of them being harmed (or abandoned) is extremely high. There is no one else who can connect with the family, or has recently seen the family. There is no safety plan and one cannot be developed with the family over the phone.

Scaling Question #3

On a scale of 0-10, thinking about all of the children, youth and families we have to work with in the midst of isolation and COVID-19, where:

- **10** = a visit from a caseworker would be useful in normal circumstances but the situation as it is now can be easily managed by a collaborative effort by the family, network, community members and the CI practitioner. This can be done either through a visit outside the home with social distancing, texting, calling, video, photos or other technology. This approach will give everyone confidence in the safety of the child(ren)/youth; and
- **0** = the situation today is so concerning that it requires a caseworker to see the child(ren)/youth in person and family to lead a safety planning process.

Scaling Question #4

On a scale of 0-10, thinking about all of the children, youth and families that we have to work with in the midst of isolation and COVID-19, where:

- **10** = I can think of at least two people (family or network) to collaborate with. There is another way to assess the safety of the child that does not include me going out today; and
- **0** = there is no one we can collaborate with to help build safety for the child. The only way to assess the safety of the child is for **ME** to see the family today.

Decision Making and Process Considerations

Once the worker provides their number, ask them to identify what would bring them up to their number, and what would bring their number higher. They should be able to articulate, in behaviourally specific language, what the harm and danger is; what the existing safety and strengths are; and what we know about a plan and/or people who are in place to help. From there, the next steps in assessment will be determined in the following way:

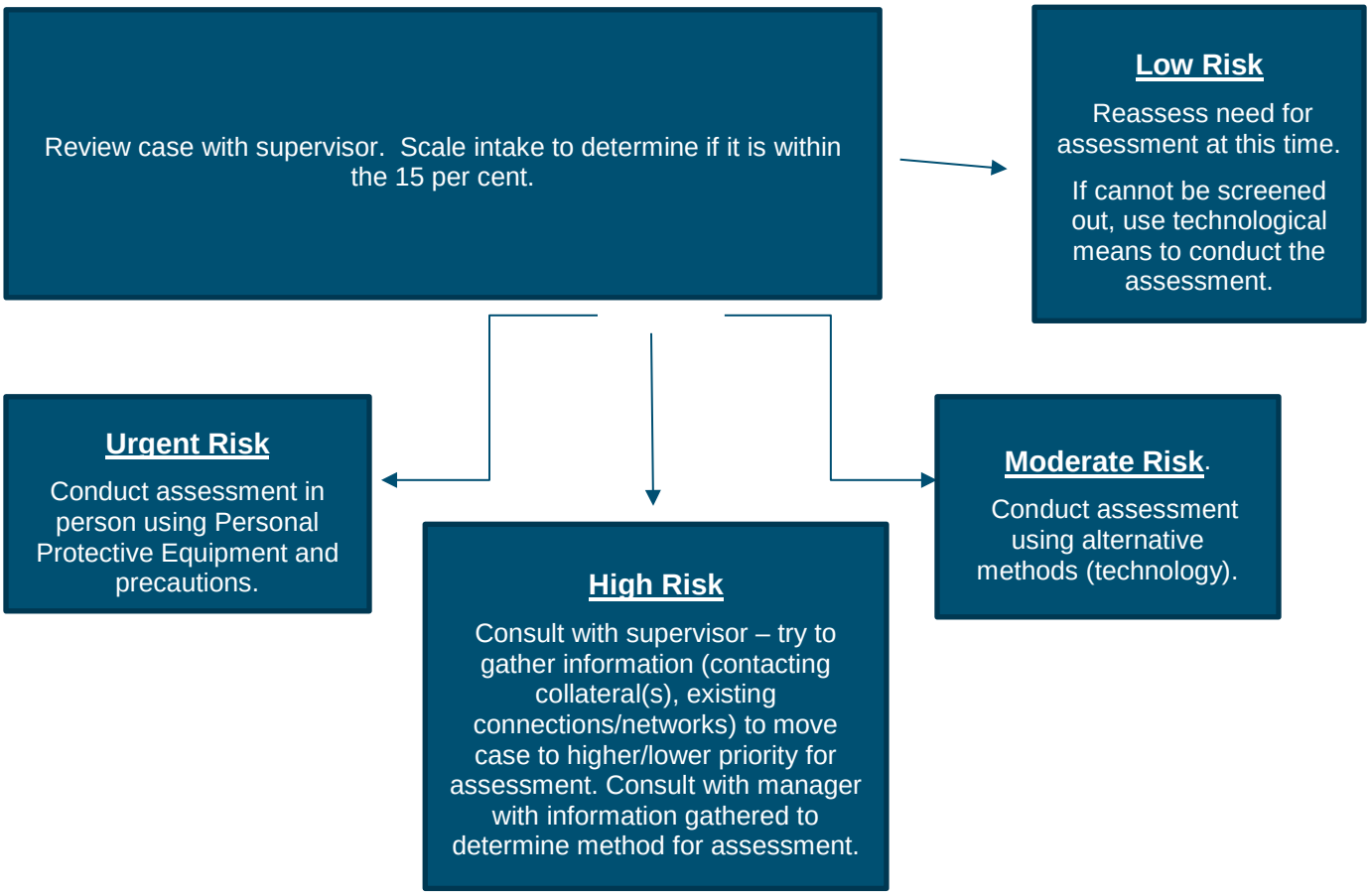
1. If the decision is to go out and complete an assessment face-to-face because it is deemed urgent, what steps will be taken to ensure everyone's safety?
2. If the decision is to complete the assessment through means other than face-to–face, what method (Skype, FaceTime, etc.) will be used? Who will use it and with whom? How will it be used? What will it be used to determine? What questions need to be asked? Who needs to be consulted?
3. If the decision is not to complete the assessment at this time but to hold for services at a later time, when is follow up required? Who will be responsible for ensuring follow-up occurs? What will the follow-up look like? What action needs to be taken?

*Note: If the decision is for the assessor to complete a face-to-face visit, consultation must also occur minimally with a manager in order to develop a plan that will keep everyone as safe as possible. All assessments that do not require an immediate response must be reassessed every five days (business days, not including weekends).

Additional Scaling Question

On a scale of 0-10, thinking about all of the children, youth and families that we have to work with in the midst of isolation and COVID-19, where:

- **10** = there are some worries but nothing that requires an immediate CS response. We are confident there is a plan/people in place that ensure the child(ren)/youth's immediate safety and we can conduct the rest of our work remotely, and/or we are confident the support network has and will continue to regularly lay eyes on the child(ren)/youth, and support networks have had regular contact with CS; and
- **0** = we cannot know if the child(ren)/youth's immediate safety is ensured unless we see them in person. We have not attempted to or are unable to contact someone in the network who could help, possible remote contact options don't increase safety or our confidence, seeing the child in person is the only way to fulfill our legislative responsibilities, and if we don't do something immediately, the child could be seriously harmed.



The draft algorithm indicates the following action based on the scoring:
Low Risk – reassess need to provide a response at this time. If possible, screen out. If not, proceed with assessment using technological means.

Moderate Risk – conduct the assessment using electronic means.

High Risk – consult with supervisor and attempt to gather more information to provide additional clarity on the intake call – can we collect more information to support scoring the matter lower on the scale? In the event that agreement cannot be met, engage a manager for third person consult.

Imminent and Severe Risk – conduct an assessment in person using necessary screening questions and Personal Protective Equipment when necessary.

Click **here** to return to the Table of Contents.

Date Released:
March 31, 2020

Date Updated:
April 21, 2020

COURT AND LEGAL MATTERS

To protect the health and safety of all court users, the courts are limiting all regular operations until further notice.

All levels of court continue to hear urgent matters. At this time, child protection matters will continue to be heard in the Provincial Court of Alberta.

The courts will determine how Child Intervention (CI) matters will be handled on a case-by-case basis. The Child Intervention practitioner will consult with the assigned lawyer through Family and Surrogate Court Litigation (FASCL) to discuss the legal status of any particular case. If a court date has been postponed, the FASCL lawyer will direct next steps and notification to interested parties. The terms and condition of each order will remain in effect.

The Alberta Courts website will be updated daily with new information regarding court processes. Please check this site for the most up-to date information. Announcements from the Alberta Court of Queen's Bench and the Provincial Court of Alberta are linked for your reference.

Terms and Conditions of Court Orders

Children's Services is required to comply with each Court Order. All court ordered terms and conditions must be satisfied. Each court order should be reviewed on an individual basis to determine how compliance with the Court Order can be achieved within the current guidelines of Alberta Health and the Chief Medical Officer of Health. If a concern arises with Children's Services ability to comply with a Court Order, please contact your legal counsel for legal advice. In some situations, it may be necessary for legal counsel to return to court to seek to vary the Court Order.

Access and Visits

Questions have been raised concerning court ordered access. Our primary concern is ensuring the safety and well being of staff and children, youth and their parents. Maintaining a child's connections continues to be important, probably more so in challenging times. All staff must follow Alberta Health and Alberta Health Services (AHS) guidelines to mitigate the risk of COVID-19. We are required to comply with court orders that issue direction regarding access.

At this point in time, workers who are required to comply with court ordered access are directed to case conference with the casework supervisor, manager and family regarding how to ensure access occurs in accordance with the court order Alberta Health and AHS

guidelines. The case conference should include a discussion of potential use of telephone conference, video conference or other approaches to comply with court ordered access. If face-to-face contact is planned for a visit, then all staff, including agency staff, must ensure they are following AHS guidelines to mitigate the risk of COVID-19.

Review each Court Order to ensure compliance with all terms and conditions, including access terms and conditions. Consult with legal counsel if there are any concerns with complying with the Court Order.

Assessments and Testing

Court Orders may require assessments or drug testing. Compliance with Courts Orders is required. Document activities showing compliance with Court Orders. Consult with legal counsel if there are concerns with compliance with each Court Order.

Therapy Counselling and Treatment

Court orders may require therapy, counselling or treatment. Compliance with Courts Orders is required. Document activities showing compliance with Court Orders. Consult with legal counsel if there are concerns with compliance with each Court Order.

Court Procedures

Discuss service requirements with your regional court services staff, court coordinator or legal counsel.

In response to the current COVID-19 pandemic, the provincial government passed an amendment to the Provincial Court Act, which allows for electronic documents. There may be options offered in your region for the electronic signing of court documents and filing by email and fax submission. This service may not be available in all courts. Discuss court document requirements with your Regional court services staff, court coordinators or legal counsel.

Signing/Extending Agreements

At this time, meeting with families to sign agreements should not occur. In-person meetings with families would not comply with the current guidelines of Alberta Health and the Chief Medical Officer of Health. In cases where a Family Enhancement Agreement with Guardian, Enhancement Agreement with Youth, Custody Agreement, Support and Financial Assistance Agreement or Support for Permanency Agreement needs to be amended or extended, facilitate a case conference to discuss the terms of the agreement and any changes/ extensions that all parties would like to see. This case conference can be held virtually through videoconference.

- If an agreement is reached, document the conversation in a contact log in CICIO.
    - Create a new agreement with the details of the agreement identified in the plan. Upload this plan into CICIO. Indicate in the agreement that the terms were discussed during a case conference that is captured in the contact log.

- Provide a copy of the new agreement to all relevant parties (via email or postal mail). If necessary schedule a follow-up conversation to ensure they understand the agreement.
- Once satisfied that the client understands the new agreement obtain their agreement by one of the following options:
    1. **Electronic Consent** - by sending the following phrase to request the client to send their electronic consent:
        - "Please respond to this message and indicate if you are in agreement with the terms and conditions of the attached [TYPE] Agreement of [DATE]"
        - If the client responds electronically with their consent, the caseworker will indicate on the agreement in the client signature space that "agreement provided electronically by [name of case worker], consent attached"
        - Both the agreement and electronic consent must be attached in the Legal Action section of CICIO (refer to the CICIO guide on attaching legal documents).

    2. **Paper Consent** - by having the client sign a printed copy of the new Agreement and returning to the caseworker by scanning the signed document, postal mail or dropping it off in person at an office.
        - If the client responds with a signed copy of the agreement, scan and upload the agreement into CICIO.

    3. **Verbal Consent** – if the client does not have the means to an electronic device or ability to return a paper copy, confirm they have read and reviewed the Agreement.
        - Document that you have shared the Agreement with them verbally in a contact log and that they have provided their consent.
        - On the client signature line of the Agreement, indicate:
            - Consent was taken verbally from [NAME] and see contact long dated [DATE]
            - Sign or add the case worker information
            - Upload the Agreement into CICIO.

- If an agreement cannot be reached, despite the presentation of alternatives, then the parties can terminate the agreement if they see fit.
    - If the agreement is terminated then CS will need to determine whether more intrusive steps are necessary.
    - Document this conversation in a contact log in CICIO.

Legal Authorities

In accordance with our standard practice, it is necessary to monitor legal authorities and any associated expiry dates. It is the caseworker's responsibility to address any legal authorities

that are expiring during the COVID-19 Pandemic. Please note, that while many court matters are being postponed for 10-weeks, Child Intervention matters are still being heard as urgent matters. Our standard practice to consult with the assigned legal counsel regarding the particular legal authority and next steps continues. If a matter is adjourned, your legal counsel will advise of the date that the matter is adjourned to.

Any changes to existing court orders and new orders (including interim orders) need to be updated in CICIO.

In cases where you do not receive a copy of the current court order in a timely manner from the courts and are asked to provide a copy to medical professionals for a child's treatment, follow existing practice in your Region/DFNA. Consult with your supervisor/manager and/or legal counsel about what documentation can be provided to demonstrate Children's Services legal involvement with the child/family.

Compliance with Courts Orders is required. Document activities showing compliance with Court Orders. Consult with legal counsel if there are concerns with compliance with each Court Order and maintaining the appropriate legal authority.

Complying with "An Act Respecting First Nations, Inuit and Métis Children Youth and Families"

During the COVID-19 health crisis, Children's Services is still required to comply with the Federal Legislation. In particular, it is important that we address the following when working with Indigenous children and families:

- Section 12 - Providing advance notice of significant measure (legal proceedings) to a child's parent, caregiver and Indigenous Governing Body (IGB).
    - The "**Notice of Significant Measure**" form that can be found on the **CI Portal** can be shared electronically as well as via mail during this time. It does not need to be provided in person.
    - As per usual case practice, if the child's safety prevents the advance notice of a significant measure, document in detail the reasons why advance notice was not provided in CICIO.
    - Document how notice is provided in all other cases.
    - Notice to an IGB is only required in situations where there the Federal Government has formally recognized an Indigenous group as an IGB. However, workers should continue to connect and consult with Indigenous partners, including the band designate, Métis resource person and DFNAs whenever possible and appropriate regarding planning for Indigenous children and families.
- Section 16 (3) -The family unity provision requires that CS reassesses a child's placement to determine if a child can return home to their parent(s)/guardian(s) or their family.
    - Workers should continue to work with families via case conference and family and natural support meetings that can be conducted via telephone or

videoconference to address concerns and determine a plan for a child returning home.

- If a child was in the process of returning home or to family and those visits were required to be postponed due to the COVID-19 health crisis, continue to facilitate regular access for the child and their family as you would for court ordered access.
- Document the efforts to keep the child connected to their family during this time and the plan for the transition once the health crisis has ended.

Additional Information

For additional information, consult your regional court services staff, court coordinator or legal counsel.

For additional information regarding the operation of Provincial Courts in relation to family and child protection concerns, please visit **AlbertaCourts.ca** for the most up to date information.

The Provincial Court website provides guidance for Calgary and Edmonton Provincial Courts regarding which matters will be heard, where and how they will be heard.

For the ***Calgary Provincial Court Pandemic Plan*** click **here**.

For the ***Edmonton Provincial Court Pandemic Plan*** click **here**.

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Date Released:	Date Updated:
March 31, 2020	April 16, 2020

ONGOING CONTACT WITH CHILDREN, FAMILIES AND PARTNERS

Effective immediately, Child Intervention (CI) standards such as face-to-face contact every three months and monthly contact with children, families and caregivers is suspended. While ongoing contact is required in order to support children and families with open files, consider alternative approaches to maintaining contact through email, telephone, Skype, etc. There may be circumstances where face-to-face contact is required. All staff must follow Alberta Health and Alberta Health Services (AHS) guidelines to mitigate the risk. Before conducting any face-to-face or in-person contact, consultation with a supervisor is required.

If case conferences have been scheduled, consider whether or not they need to proceed or whether or not they can be done via teleconference, Skype, etc. If in-person contact is necessary, please use all precautions advised by Alberta Health and AHS, including social distancing, cleansing of spaces, etc.

As of March 16, 2020, all group care and residential facilities are being asked to limit onsite guests to *essential visitors only*.

Family/Sibling Visits

CI Practitioners will need to continue to maintain contact with families; however, alternate options in place of home visits and face-to-face meetings should be used, such as FaceTime, Skype, phone or text. There may be circumstances where face-to-face contact is required. All staff must follow Alberta Health and AHS guidelines to mitigate the risk. Before conducting any face-to-face or in-person contact, consultation with a supervisor is required. If you, as a contract service provider, have been a part of facilitating access, you will be involved in those discussions.

Attending Funerals and Wakes

If a child in care's family member dies, they need to be supported to connect and receive comfort. If a family member passes away and a wake or funeral is being held, support the child in attending the funeral in person if the funeral/wake is following Alberta Health and AHS guidelines, including:

- The funeral/wake has no more than 15 individuals;
- Social distancing (two meters) can be maintained; and
- The child will not be participating in activities that promote disease transmission (e.g. singing, cheering, close contact, sharing food or beverages, buffet-style meals).

If the child cannot attend the funeral/wake in person, explore other options to have the child attend the funeral/wake virtually, such as Skype or FaceTime.

Social Media

In order to stay connected and facilitate virtual meetings with our children, youth and families, the use of social media apps such as WhatsApp, Facebook and Messenger are approved for staff to download and use.

When creating social media accounts at this time, please ensure your supervisor or manager is aware an account has been made. Personal accounts **SHOULD NOT BE USED** to connect with children and families. Please ensure the privacy settings are set to the most secure. Any social media accounts should be identified as professional accounts by the use of "Children's Services" in the account name.

First Nation and Band Consults

In-person band consultations are currently on hold; however, maintaining connections of a child to their community continues to be important, so please consider alternative approaches through telephone or Skype.

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March 31, 2020	April 16, 2020

HOME VISITS

Effective immediately, home visits should no longer occur for regular, ongoing case management activities. Home visits should continue for urgent matters that require immediate attention at intake, assessment or that arise during ongoing case management.

For unannounced visits such as urgent matters, the initial contact and screening will take place at the door, where the worker will ask pertinent questions regarding risk of illness in the home.

If Child Intervention (CI) staff have been asked to respond to a home on an urgent matter and have determined someone has symptoms or has been exposed to COVID-19, **THEY ARE NOT TO ENTER INTO THE HOME.** If immediate action appears to be required, the appropriate emergency service will be called to assist before attending to the matter.

Screening Questions

When required to attend a pre-arranged face-to-face meeting for urgent matters outlined above, contact the client, agency or community partner and ask the following screening questions as per Alberta Health and AHS screening criteria:

- Have you travelled outside of Canada within the last 14 days?
- Have you had close contact with a confirmed or probable case of COVID-19?
- Have you had close contact with a person with acute respiratory illness who has travelled anywhere outside of Canada within the last 14 days before their illness?
- Have you had laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19 virus?
- Is there anyone in the home with a fever and/or a cough or shortness of breath?

A close contact is defined as a person who:

- Provided care for the individual, including healthcare workers, family members or other caregivers, or who had other similar close physical contact with the person without consistent and appropriate use of personal protective equipment.

OR

- Lived with or otherwise had close prolonged contact (within two metres) with the person while the person was infectious.

OR

- Had direct contact with infectious bodily fluids of the person (e.g. was coughed or sneezed on) while not wearing recommended personal protective equipment.

If the client or any member of the home does not present with any of the criteria, proceed with the visit. If the client or any member of the home states they meet some of the criteria, try to

reschedule the visit for a time when they are symptom free or use alternate options such as FaceTime, Skype, phone or text if available.

If the client or any member of the home indicates they are sick and have a confirmed case of COVID-19, do not attend the home and cancel all non-essential home visits or meetings.

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Date Released:	Date Updated:
March 31, 2020	April 22, 2020

SUPPORT AND FINANCIAL ASSISTANCE AGREEMENTS

Message from Statutory Director

The courts recently placed an injunction on the Regulation change that was to come into force on April 1, 2020, reducing the age of eligibility. The proposed change to the SFAA program to decrease the maximum age of recipients from age 24 to 22 **IS NOT PROCEEDING** at this time.

SFAA Directive issued by Elden Block, Statutory Director on March 27, 2020:

> Justice Friesen of the Court of Queen's Bench has ordered an interim injunction prohibiting a change in the Support and Financial Assistance (SFAA) program, which would have lowered the age eligibility requirement from 24 to 22. The change, proposed to take effect on April 1, 2020 through amendments to the Child, Youth and Family Enhancement Regulation, will **not** take place while the injunction is in effect. The court has prohibited government from lowering the age limit pending a trial on the merits of a specific case. **Therefore, the maximum age for eligibility for the SFAA program remains age 24**.
>
> I direct compliance with the court's direction. The Director's administration of the SFAA program will continue unchanged, including the availability of an administrative review and appeal for SFAA recipients. Individuals notified of a change in the SFAA program effective April 1, 2020 are to be notified that the proposed change will not take effect.

The ministry will maintain its commitment to the temporary transition funding and support arrangements that have already been negotiated. However, if any young person age 22-24 who meets the criteria for SFAA as per existing policy under the *Child, Youth and Family Enhancement Act* wishes to enter into a SFAA, they may contact their worker to make those arrangements. Existing policy should be applied in determining what services and supports will be negotiated.

Contact

To maintain appropriate physical distancing, the negotiation of an agreement, and any terms or supports, can occur electronically and entered into CICIO.

- Additionally, you will need to review the circumstances of those young adults who had a transition plan, but for whom circumstances may have now suddenly changed. For

example, young adults who no longer have child care as a result of recent facility closures.

- In principle, we must assume many of the transition plans and resources that have been organized for these young adults may not be readily available. We will need to be flexible and responsive to their changing needs.
- Due to the pandemic, home visits should no longer occur for regular, ongoing case management activities. Home visits should only occur for urgent matters that require immediate attention at intake, assessment or during ongoing case management. That said, young adults will still require support and Children's Services (CS) will attempt to ensure they remain connected to their family and natural supports within the guidelines provided by Alberta Health and Alberta Health Services.
- In order to stay connected and facilitate virtual meetings with young adults, the use of social media apps such as WhatsApp, Facebook and Messenger are approved for staff to download and use. When creating social media accounts at this time, please ensure your supervisor or manager is aware an account has been made. Personal accounts SHOULD NOT BE USED to connect with children and families. Please ensure privacy settings are set to the most secure. Any social media accounts should be identified as professional accounts by the use of "CS" in the account name.
- Caseworkers should provide weekly check-in's/calls with young adults.

Financial Support

Those young people who already had bridge funding set up, and who want to continue on this transition path, will be approved to do so.

Bridge funding approval forms must be signed by the appropriate provincial leads/designated staff. Approval forms are to be filed in the Legal section of the CYFE client file. In order to support the timely implementation for bridge funding, financial expenditures should follow the following documentation process:

CODING AND PAYMENT PROCESS

1. The SFAA agreement for an approved client must have either an expired or end dated legal authority but must remain unclosed in CICIO for the duration of the bridge funding – this allows clients to continue to have a usable and active ID#.
2. Payments directly to clients may be made through CYFS and to Contracted Agencies through CMAS using standard procedures and processes.
3. SFAA Transition tool # 1 Updated March 4, 2020
4. Financial coding should follow the typical SFAA case structure:
    a. client ID #;
    b. program code 01469 (SFAA);
    c. Account code as per service:
    d. Period of Assistance (POA); and
    e. Enter – "Bridge Funding [Month]" in the Cheque Message/payment message

Common Account Codes:

1. Living allowances (rent etc.) - 527100 (Supported Independent Living)
2. Contracted facilities - 527110 (Payments to Institutions)
3. Support worker – 543480 (Community Youth Worker)

Regions must ensure a client list is tracked offline in the regional SFAA Transitions Workbook which includes client ID #.

File closures in CICIO can occur post Bridge funding completion.

All other young people who are eligible for a SFAA will be able to enter into an agreement and negotiate financial supports as usual.

- Caseworkers must continue to provide emotional support to young adults during and after the pandemic, regardless of their status. When connecting with young adults with an active SFAA, please follow the **on-going contact with children, families and partners** directive outlined in the **CI Practice Guidance** found on the CI portal.
- CS, Community and Social Services and Advancing Futures must work collaboratively at all times to ensure young adults' needs are met. This is especially true during the COVID-19 Pandemic.

Alberta Works - Income Support

When appropriate, CS will continue to refer young adults for Income Support to Alberta Works.

Until further notice, Alberta Supports Centres are suspending in-person services; however, are taking applications online and by telephone. More information can be found **here.**

Due to interim measures in response to the COVID-19 outbreak, it is expected to take several business days to process the first payment rather than the usual timeline of three to five business days.

If a young person has an Income Support application in progress and has questions or concerns, they should contact the worker who assisted them or call the Alberta Supports Contact Centre at 1-877-644-9992, or in Edmonton at 780- 644-9992.

Persons with Developmental Disabilities /Assured Income for the Severely Handicapped

Allocation of CS post-SFAA temporary funding will not affect eligibility if a Persons with Development Disabilities (PDD)/Assured Income for the Severely Handicapped (AISH) file **has not** been activated.

CS should continue to allocate temporary funding as needed for young adults and others with complex needs. Existing post-SFAA temporary funding allocations will be honored until the end of the agreement term. If additional funding is required, young adults should be given the option to sign a new SFAA or extend their temporary funding arrangement for a limited time. Caseworkers are to sign new SFAAs with eligible young adults who require ongoing support from the ministry.

Advancing Futures Bursary

The Advancing Futures Bursary (AFB) program's primary focus is ensuring all AFB youth are safe and continue to have access to their psychosocial supports and funding currently in place.

Program coordinators are now working from home and continue to provide day-to-day support to youth on their caseloads.

- Although AFB is not providing face-to-face meetings, they are connecting with youth via the phone, e-mail, Skype, FaceTime and text.
- Offices will remain closed to walk-ins during the pandemic.
- AFB funding is taxable.

If you have any questions, please email: **CS.AdvancingFutures@gov.ab.ca**

Provincial and Federal Funding

The provincial and federal governments are providing a number of financial relief programs to help those in need of assistance during the COVID-19 pandemic. These programs are not being managed through Alberta Supports. You can access more information about **Emergency Isolation Support** on the Alberta.ca website or by calling 310-0000.

For more information and to apply for federal assistance programs, including Employment Insurance, go to the service **Canada Website.**

If the young adult is not receiving income support, they can still apply.

Support Services

Mentoring Program

The Mentoring program serves young adults up to the age of 24. Please keep the following in mind when accessing this program:

- It typically takes a few months to process Mentoring program applications.
- Approved applicants are placed on a waitlist until a suitable mentor is found. This can take several months.
- Once matched, the applicant can access supports from their mentor for up to one year.
- As such, the Mentoring program may not be an appropriate resource for new applicants or those with a pending 24th birthday, so alternative supports must be provided.
- Young adults with an existing mentor can continue to receive this support as agency contracts have not been impacted by the upcoming regulatory SFAA age change.
- In light of COVID-19, the Mentoring program is only providing supports via phone, text and skype as offices have been closed to the public.
- If you have questions, please connect with the program.
- More information regarding the Mentoring program can be found **here**.

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ADOPTION AND PRIVATE GUARDIANSHIP

Plans to move forward with pursuing legal permanency by current caregivers can continue. If the case team supports the plan, as per policy, the *Addendum to Home Assessment Report (Child Specific – Legal Permanency)* [ADOP12108] should be completed.

Application packages can be prepared and if the court agrees to file, then it becomes a question of when a judge (private guardianship) or justice (adoption) can review the matter and grant the order. With the current COVID-19 Pandemic, the courts have paused hearing and reviewing any non-emergent matters. As such, not all judicial centres will file an application at this time, and these matters will have to wait until courts resume their normal activities.

If you are unable to file an application at this time, address or complete any requirements and processes that are independent of other systems in anticipation of when courts will resume full operations.

Planned Transitions

For cases where legal permanency and transition periods were already planned, they should be reviewed on a case-by-case basis with the case team, as circumstances are variable. Dependencies in decision-making around proceeding with a planned transition include:

- whether travel is involved;
- how long a transition is planned for;
- number of visits;
- the comfort level of all involved in having contacts/exposures at this time; and
- whether the transition had already been underway or not.

If a transition had not yet commenced, it may be best to initiate it once current measures for social distancing and avoidance of any non-essential contact are lifted.

Information Sharing with Potential Adoptive Parents

As per policy (5.3.1), information sharing is a staged process. Undertaking it requires that the Confidentiality Agreement and Acknowledgement of Information Shared [ADOP11368] be reviewed and signed with the prospective legal permanency family. Signing of the document can be accomplished through email, and if there is no capacity to scan a copy, a photograph of the signature page can be emailed until it can be provided in hardcopy.

Once the confidentiality agreement has been signed, child-specific hardcopy documentation can be provided to the prospective legal permanency family for their review and consideration.

This documentation will have been redacted for third party information, and should the match NOT proceed, these materials are to be returned to the caseworker.

Meetings can then be set up between involved parties for further discussion of child-specific information. While in-person meetings are often recognized as best practice in information-sharing, current restrictions do not impede the process. Meetings can be conducted over platforms such as FaceTime or Skype, or through tele-conferencing.

Moving to a PPA Placement

PPA placements can be set in cases of current caregivers being ready and supported in this step. For these situations, formal information sharing is not impeded by current restrictions and can be conducted over technology. Follow information-sharing policy (5.3.1), and set PPA after all necessary processes and requirements have been met.

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SUPPORTS FOR PERMANENCY

Signing or Modifying Supports for Permanency Agreements

Policy should be referenced (12.2 Entering into an Agreement and 12.3 Negotiating Provisions) for general guidance on how to enter into and what can be negotiated within a Supports for Permanency (SFP) Agreement, and how this is to be done. Given the current restrictions to meeting with clients during the COVID-19 Pandemic, it is possible to negotiate an agreement by way of telephone, Skype, FaceTime or another platform. Reviewing and signing of a SFP Agreement can be done by email. If a SFP recipient is unable to send a scanned copy of an agreement, sending a photo of the signed agreement is acceptable for the time being. All agreements should be captured in the electronic case management system. For information regarding **Signing/Extending Agreements**, please see "**Court and Legal Matters**".

Additional Respite

The number of hours a family can receive respite services for in any given year is regulated at 576. Per Regulations, there is no capacity to increase the number of hours for respite under SFP. If the family has not negotiated for the maximum number of hours allowable in their current SFP Agreement, a new agreement can be entered into that provides for a greater number of hours. If the family has already negotiated for the maximum allowed under SFP, and the child qualifies for Family Support for Children with Disabilities (FSCD) services, additional hours through FSCD could be explored.

Additional Needs Funding and Exceptional Circumstances

SFP provisions are strictly regulated, so latitude can only be exercised within their established parameters. For instance, respite can be used strategically, as can additional needs funding, so long as maximums allowed within the regulation are not exceeded.

For example, if a child's facility is closing necessitating the child's return to the family home, and the family is having or likely to have difficulty managing the child's needs, the case team should first work with the family to identify natural supports and other available support services they can access. If the child is eligible for FSCD support, for instance, collaboration with that program to broker support services is appropriate.

Family circumstances will vary; however, if the SFP case team determines a breakdown is likely without provision of exceptional supports, an assessment for Intervention Services may be indicated.

Additionally, if it has been confirmed that due to school closures a child will need technology in order to support their continued learning, and the school is unable to provide the child with the necessary technology, additional needs funds can be applied to purchase the required device(s). Under normal circumstances, additional needs funds could be used for such a purpose if it was agreed in negotiation that it meets an emotional or behavioural need of the child. This provision has a lot of latitude, intentionally.

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MEDICAL APPOINTMENTS

Current policy 9.1.3. Medical Care should still be followed. If children and youth require medical attention during the COVID-19 pandemic, it is important that child/youth has access to appropriate medical care. Whenever possible, the child/youth should see their regular physician for any medical concerns that arise. The caregiver should take as much responsibility as possible for arranging the examination.

Document all appointments, details of treatments, consultations and decisions in a contact log in the electronic information system. Ensure that the outcome of the examination, whether any further follow up is required, and the name and contact information for the physician is documented in a contact log and under the medical tab in the electronic information system. If a child or youth has had a medical, dental or optical examination, obtain the results from the caregiver and record the results in

If the child is showing symptoms of COVID-19, the AHS online health assessment should be completed and Health Link 811 should be called for further information if directed by the self-assessment tool and how to access testing if required. If a child/youth tests positive for COVID-19 or is required to self-isolate based on Alberta Health Guidelines, the COVID-19 Reporting form (found on the CI Portal) needs to be completed and sent to CS-CI-COVID-19@gov.ab.ca.

Immunizations

If a child or youth is scheduled to have routine immunizations given based on the Alberta Health Services (AHS) guidelines, these appointments should continue to occur during the COVID-19 pandemic. It is important that public health guidelines are followed to maintain social distancing while out of the home and that guidelines of individual medical offices are also adhered to. If a child or caregiver is feeling unwell or has symptoms on the date of appointment, the appointment should be rescheduled to a later date.

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Updated

Date Released:	Date Updated:
March 31, 2020	May 01, 2020

DOCUMENTATION

Child Intervention Practitioners are being asked to record and track situations of suspected and/or confirmed COVID-19 cases. Please report any information related to a child receiving services (in care or not in care) and/or a parent or caregiver (foster/kinship) who meets the **criteria for mandatory self-isolation** according to Alberta Health and Alberta Health Services. Please complete the **COVID-19 Reporting Form** and send it to **CS-CI-COVID-19@gov.ab.ca**. Once a reporting form is submitted please ensure updates are submitted when the child receiving services (in care or not in care) and/or a parent or caregiver (foster/kinship) no longer have symptoms, are no longer self-isolating and/or receive their test results.

Youth Subject to a Medical Officer of Health Order to Isolate

For any youth who is the subject of a Medical Officer of Health Order regarding non-compliance or refusal to isolate and is to be remanded to a facility identified by AHS for isolation:

1. If the youth has not yet been remanded to the facility for isolation, the caseworker should contact the appropriate police authority to locate/transport the youth to remand.
2. The youth's delegated worker will be identified as the key contact to AHS and the facility, including their office phone number and/or work mobile number.
3. If a decision that a youth is subject to a Health Order occurs after hours, contact the 24-hour Child Intervention Line (1-800-638-0715) and a delegated worker can respond as required.
4. A special caution needs to be entered into the electronic information system (CICIO), by the delegated caseworker or after hours worker, identifying the youth is subject to a Health Order and the facility they were placed in.

Notification to Parents

For any child that has been directed to self-isolate, is being tested for COVID-19 or has tested positive for COVID-19, notification to the child's parent(s) is required for all children in temporary care. If a child is in permanent care, but maintains contact with their parent(s), notification is also required. Any updates on a child's status should also be communicated to the parent(s). **THIS IS THE RESPONSIBILITY OF THE CASEWORKER.**

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Forms:
COVID-19 Reporting Form

Date Released:	Date Updated:
March 31, 2020	April 24, 2020

INTERVENTION RECORD CHECKS

As of March 19, all IRCs can be sent to the centralized IRC mailbox for processing – **CS-IRCrequest@gov.ab.ca**.

The IRC has been converted to a digital form and can be accessed on the CI Portal. This should be completed electronically and emailed to the centralized IRC mailbox for processing.

The following instructions for completing the digital IRC form should be provided to the individual requesting the IRC:

- They need to have Adobe Acrobat Reader on their device to complete the digital form.
- Do not print out the digital form to complete. This should only be completed digitally.
- Ensure all sections on the first page are complete, including consents where they need to check the tick box, type in their name, and fill in the date,
- Attach a scan or photo of 1 piece of their identification,
    - The ID should include the requestor's name, birth date and signature.

This digital form is intended for use with agencies, caregivers and members of the public required to have an IRC completed.

If the IRC request is received at an office site – staff are to scan all of the documents required (form and identification) and email them to **CS-IRCrequest@gov.ab.ca** (we would like to keep everything electronic as there may be significant mail interruptions).

If the office gets a call from the public, as there is not an office open to receive the documents, staff are to ask the requester to scan all documents needed for the request (form and identification) and email them to **CS-IRCrequest@gov.ab.ca**.

The completed IRCs will then be sent back the region or the individual who requested it.
If the requester has any questions or if they receive a positive check they were not expecting, they can email their questions to the centralized IRC email; it will be monitored and answered by email or telephone call, if requested.

For group or congregate care homes, IRCs may be completed at this time without scanning and sending a copy of the completed IRC form and identification to the centralized email. This is in order to expedite the onboarding of new staff in group and congregate care homes.

In order to complete an expedited or informal IRC, please have the agency email the following to the individual completing the check:

- Name;

- DOB;
- Scanned copy or photograph of individual's ID (if possible);
- Driver's licence #;
- Personal email address;
- Names and dates of birth for all of their children and children they have acted as a parent for; and
- Agency they will be working with.

If the IRC is negative, the information will be emailed to the agency. If the IRC is positive, the information will be emailed to the individual requestor.

Once completed, please forward the above information, along with the outcome of the IRC, to **CS-IRCrequest@gov.ab.ca** so we are able to track these informal IRCs.

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CRIMINAL RECORD CHECKS

Agency Staff

Due to the COVID-19 Pandemic, the Statutory Director is authorizing all Category 4 Directors the ability to authorize agencies on an as need basis to use Statutory Declarations [CS2557] as an interim measure for Criminal Record Checks (CRCs) for staff who are urgently required to support children and youth under the *Child, Youth and Family Enhancement Act*. This must be tracked and confirmation recorded once the formal CRC has occurred.

Wage Staff

On an emergent basis, the Statutory Director has authorized Regional Directors and Human Resources to allow for a CRC that has been completed within one year along with a Statutory Declaration [CS2557]. The Statutory Declaration is to include a statement by the applicant that they are declaring they are not under investigation and have not had any criminal charges or convictions since the last CRC. This must be tracked and confirmation recorded once an updated CRC has occurred.

Criminal Record Checks - Options

During the COVID-19 Pandemic, CRCs remain a vital part of our work. Prior to the COVID-19 Pandemic policies, systems and practices have been in place for informal and formal CRCs. Please continue to use established processes first.

Some police detachments have indicated they currently cannot complete CRCs. When you encounter this barrier, the following options can be utilized.

Criminal Record Checks for Immediate Placements

Following unsuccessful attempts to utilize existing procedures and relationships:

- RCMP partners attached to Child Advocacy Centres (CACs) can provide emergency, informal CRCs if necessary:
  - Calgary & Area CAC:
    - Cpl. Michelle Burke, 403-428-5474, cell 403-470-25889
    - Cst. Gabby Spencer, 403-428-5394
  - Central Alberta CAC:
    - Sgt. Ian Ihme, 403-406-2421, cell 403-3522650
    - Cpl. Holly Erb, 587-272-2233, cell 403-392-0431
    - Cst. Holly Porterfield, 403-272-2233
  - Zebra CAC:

        - Cpl. Angela Heath, 780-391-4255, cell 780-915-3652
        - Cst. Rosanne Vandenbilche, 780-391-5068, cell 780-880-7763
        - Cst. Sadie Bulger, 780-391-5109
        - Cst. Erin Sowers, cell 780-232-0659
    - Caribou CAC:
        - Cpl. Michelle Mosher, 780-814-7223, cell 780-343-5635
    - Wood Buffalo and Little Bear CAC do not have full-time assigned RCMP staff. Please utilize detachments.
- For after-hours inquiries, if the CAC staff are unavailable, call the RCMP Operational Control Centre at 780-400-5810 and ask for the on-call provincial GIS member.
- **Note:** further RCMP resources available after hours are being explored, and will be updated in future Practice Guides.

Formal Criminal Record Check

Following unsuccessful attempts to utilize existing procedures:

Edmonton Police Service (EPS) now has an online option for obtaining CRCs at https://secure.tritoncanada.ca/v/public/landing/edmontonpoliceservice/home (use Chrome when accessing this site as Explorer does not work).

- **Note:** The EPS online system can only provide CRCs with Vulnerable Sector Checks for the **greater Edmonton area**. If the applicant lives outside of the greater Edmonton area, and only requires a CRC (not a Vulnerable Sector Check), EPS can accommodate.
- The greater Edmonton area includes the communities of:
    - Beaumont
    - Sherwood Park
    - St. Albert
    - Morinville
    - Fort Saskatchewan
    - Leduc
    - Spruce Grove
    - Stony Plain

The EPS online system Vulnerable Sector Checks are continuing, but are only open to do fingerprinting by appointment on Fridays.

New Kinship Caregivers with Existing Criminal Record Checks

Policy 2.1.2 Kinship Care Application and Approval Requirements (Placement Resources) states CRC results must be current within six months of the date of the application. This requirement for existing CRCs is being extended in the interim to 12 months.

Respite and Relief Caregivers

Respite: If a caregiver is unable to provide care, respite caregivers are licensed and already have the required CRCs to care for children temporarily placed in their care.

Relief: As per current policy, CRCs may be considered additional information requested by the caseworker (see Policy 3.4.3 Relief Care Placement Resources). If there are barriers to obtaining a CRC, follow the instructions above. Similar to the needs of immediate kinship placement, policy allows for the use of a Statutory Declaration [CS2557]. Consider and evaluate other sources of information, including immediate collaterals, reference checks, the voice of the child (as age appropriate) and cross-reference any information found within an Intervention Record Check (IRC).

Current Caregivers Requiring Updated CRCs for Licensing

If a licensed caregiver's CRC is due for renewal and expires between April 1 and June 1, 2020, extend the three year requirement by an additional three months. Make sure the expiry date is noted in CICIO and revisited in three months' time.

New Adults Residing in Caregiver Home

During this time, there may be circumstances where adults return to reside in a caregiver's home. Please follow the guidance for CRCs described above.

Further options for CRCs continue to be explored and will be updated in future Practice Guides. Should there still be barriers after following the Practice Guide and speaking with your supervisor, please email your questions to **CS-CI-COVID-19@gov.ab.ca**.

Consider and evaluate other sources of information, including immediate collaterals, reference checks, the voice of the child (as age appropriate) and cross-reference any information found within an IRC.

Click **here** to return to the Table of Contents.

New

Date Released:
April 28, 2020

Date Updated:
April 28, 2020

HOME STUDY REPORTS

SAFE Home Study, Assessment and Support for Kinship Caregiving (ASKC Pilot) and Home Assessment Reports

NOTE: This guidance is specific to applicants who are NOT current caregivers to children in government care. These applicants are seeking to become approved for kinship care, foster care, or adoption of children not yet in their care.

- The foundational practice expectation for the home assessment process is in-person information gathering. Based on current public health requirements, this requires some modification.
- These instructions are to assist workers in applying these agreed-to modifications, as necessary, to their particular case circumstances.
- Preparing and completing SAFE Home Study, Assessment and Support for Kinship Caregiving (ASKC Pilot), or regulated Home Assessment Reports (collectively Report) is a critical process in planning for children's placements and evaluating the overall suitability of both prospective and current caregivers.
- Guided by legislation, regulation and policy, the home assessment process dictates evaluation of outside evidence (e.g. Criminal Record Checks, Intervention Record Checks and medical and personal references).
- Ensuring continued evaluation and approval of placement resources is more complicated under current circumstances, necessitating adaptations in practice and pragmatic decision-making

Guidelines and Expectations

HOME STUDY REPORTS - POTENTIAL FOSTER AND KINSHIP CAREGIVERS

HSRs Underway

- If the home assessor for the HSR has had at least one interview in the applicant's home to assess safety issues, the balance of the interviews may be conducted through use of technology such as Zoom, Skype, FaceTime or other video-conferencing mechanisms.
- If SAFE is being used Questionnaire 2 **must** have been completed during the in-home interview.
- Use appropriate privacy settings on the technology to maintain confidentiality and review *Enhancement Policy and Practice Supports on Technology and Social Media Use*. (Please refer to and follow the attached *Basic Video Interviewing Tips*).

HSRs – Supporting Documentation Requirements

- The foster caregiver licensing process requires accompanying documentation before the application process can begin. Kinship Caregivers are not licensed. They do require, however, similar documentation to support placement.
- Having this initial documentation ensures that applicants meet a minimum threshold of suitability prior to starting other resource-intensive processes.
- Documentation includes Criminal Record Checks (CRCs), Intervention Record Checks (IRCs), and supporting medical and personal references.
- While acquiring and presenting documentation for review remains the responsibility of the applicant(s), under current practice conditions please assist applicants to obtain the required documentation.
- Currently, there are interim processes in place to assist applicants in completing required CRCs and IRCs. These include the use of Statutory Declarations, online CRCs and IRCs, and informal checks supported by Statutory Declarations. Please refer to "**Intervention Record Checks**" and "**Criminal Record Checks**" for more information.
- Obtaining any remaining required supporting documentation will likely require collaboration between the licensing officer or support worker and the applicant.
- For medical references, medical appointments are still available, including online appointments.
- Medical reference documentation is acceptable electronically, provided it comes directly from the office of the professional making the report.
- Personal references usually completed by telephone are expected to continue in this manner.
- Applicants may provide other supporting documents electronically.

HSRs – Interviewing via Technology and HSR Approval

- For HSRs that have not yet commenced, conducting interviews through use of technology such as Zoom, Skype, FaceTime or other video-conferencing mechanisms is also allowable. This limits potential disease exposure for both the report writer and the family and ensures our system's ability to meet the continued demand for placement resources. (Please refer to and follow the attached *Basic Video Interviewing Tips*).
- The number of interviews required to complete the HSR remains as outlined in Policy.
- If SAFE is being used Questionnaire 2 must be completed during an in-home interview.
- Use appropriate privacy settings on the technology to maintain confidentiality and review the *Enhancement Policy and Practice Supports on Technology and Social Media Use*.
- Before finalizing an HSR commenced by video-conferencing technology, a delegated Children's Services worker – e.g. a licensing officer or support worker – must conduct at least one site visit to assess the family.
    - The attending worker must read the draft Report prior to attending at the home
        - All family members should be present
        - Complete the initial *Environmental Safety Assessment for Caregivers* during this visit. This is an opportunity to interact with the family more

thoroughly and see the home fully. This is essential prior to approving a new home.
  - Should the worker find *any* concerns (relationship or environmental safety) during the visit, address those concerns.
  - The family should be aware that this visit requirement is part of the assessment process and may impact their approval
- Follow Alberta Health Services screening procedures on all family members and the attending worker prior to entering the home. Note all health screening results on the file.
- If screening indicates a health concern, follow Alberta Health Services recommendations or direction and reschedule the visit.
- Maintain proper social distancing.

HSRs – General Adoption Applicants

- Applicants for general adoption must submit all documentation required to support their application before the home assessment process may begin (i.e. a criminal record check, an intervention record check, a completed medical reference, and personal references).
- Interim processes for IRCs and CRCs are **not** applicable to general adoption applicants.
- Provide applicants with any available information and guidance on how to obtain necessary documentation.
- Where a home assessment process was previously initiated, and at least one interview was conducted in the applicant's home to assess safety issues, the balance of the of the interviews may be conducted through use of such technology as Zoom, Skype, FaceTime or other video conferencing mechanisms. (Please refer to and follow the attached *Basic Video Interviewing Tips*).Where applicants have submitted all required documentation, the home assessment process may be initiated and conducted through use of technology so long as the assessment process includes one visit to the applicant(s) home to assess safety issues. Approving the applicant(s) for adoption is contingent on this requirement.
- If SAFE is being used Questionnaire 2 must have been completed during the in-home interview.
- Refer to and follow the detailed direction provided in the above section – *HSRs – Interviewing via Technology and HSR Approval*.
- If there are case specific circumstances that require special consideration, have your case team follow a third-person consult process for joint decision-making.
- As needed, contact Adoption Services for assistance.

These guidelines are reflective of current circumstances and may be reviewed and amended as these evolve or change.

For questions on the practice guidelines, email cs-ci-covid-19@gov.ab.ca.

ACSW: Telephone or online social work services are permissible.

See: Standards of Practice section E.3 Technology in Social Work Practice and NASW, ASWB, CSWE and CSWA Standards for Technology in Social Work Practice (2017): https://www.socialworkers.org/includes/newIncludes/homepage/PRA-BRO-33617.TechStandards_FINAL_POSTING.pdf

Video Interviewing Tips

- Find a quiet, private, well-lit place, free from possible interruptions.
- Avoid coffee shops and other communal spaces.
- Ensure privacy for the interviewee. Use strong privacy controls on the technology.
- Ensure your internet connection is stable.
- Check that your computer's audio is working.
- Test your computer's webcam.
- Close any unnecessary web browser tabs and applications. Make sure you are not downloading anything in the background.
- Place your phone in silent mode.
- Position your webcam so that you have a neutral background that is free from distractions.
- Avoid the instinct to look directly at your interviewee on the screen. Instead, when you speak, you want to direct your gaze at the webcam. When you do this, your eyes are more likely to align with the interviewee's eyes on the other end.
- When you are listening, you can look back at the screen.
- Use hand gestures when it feels appropriate and keep your movements close to your body. Avoid fidgeting or letting your gaze drift away from the device.
- Set out a glass or bottle of water for yourself.
- Adjust the lights in the room. If things appear dark or dim, you may want to bring in an extra desk lamp to brighten the space.
- Throughout the interview, keep your mood upbeat and convey optimism with your body language. One way to achieve this is to have good posture. Sit in your chair with your back straight and your shoulders open. When you are listening, nod and smile when appropriate to communicate that you are giving them your full attention.

If things go wrong – it is OK to reschedule

With technology, there is always a chance things could go wrong. Here are some backup plans to have ready just in case.

- **If your video or audio stops working**
  Before the interview, ask them for a phone number where you can reach them if you experience technical difficulties. If the video cuts out, call them at that number. Ask if you can continue the interview by phone or if you can reschedule.
- **If noise interrupts the conversation**
  If noises (sirens, construction, etc.) interrupt your video interview, apologize for the interruption and ask for a few moments until the noise has subsided. You may want to mute the microphone if the noise is severe.
- **If someone enters the room unexpectedly**

If family members, housemates or pets enter the room while you are interviewing, apologize to the interviewee, ask for a few moments, mute your microphone and turn off your camera, and then step away to deal with the interruption. Make sure that the room is secure before beginning the interview again.

Click **here** to return to the Table of Contents.

Date Released: March 31, 2020
Date Updated: April 16, 2020

SUPPORTS FOR CAREGIVERS

Educational Support

This section provides guidance regarding how to support caregivers while schools are closed and learning is to be completed remotely and online.

Ministry of Education

Expectations by Grade:

- Kindergarten to Grade 6 - five hours per week with a focus on language/literary and mathematics/numeracy;
- Grades 7 to 9 – 10 hours per week with a focus on language/literacy and mathematics/numeracy with an opportunity to incorporate science and social studies;
- Grades 10 to 12 - three hours per course per week with a focus on specified and core courses required for high school graduation requirements, including language (English, French and French language arts), social studies, mathematics, biology, chemistry and physics.

Assessment

Teachers are responsible for assessing progress and assigning a final grade. Every student will receive final grades and a report card appropriate to their grade level. Grade 6 and 9 provincial achievement tests are cancelled. Grade 12 students on track to receive 100 credits or more will still be eligible to graduate. Principals have some flexibility in awarding up to 15 credits. General diploma exams are cancelled.

Teacher's Role

Teachers have already contacted, or will soon contact, families and caregivers directly to provide information about learning expectations and educational materials for their individual children. They should have assessed the family's ability to access technology in support of their children's learning. Students, especially those in the lower grades or without technology access, are often receiving paper-based learning packages, with delivery and return negotiated between the teacher and the family. Teachers may have deemed this most appropriate for these students.

Children's Services Role

As custodians and guardians of children, Children's Services (CS) has an obligation to work with schools to ensure children's educational needs are met. This includes assisting caregivers with balancing the additional pressures of caregiving and implementing education plans, as well as ensuring children and youth in care have the right tools and support to participate fully in their education.

Policy already stipulates children in care are entitled to have their education needs met and all education related expenses will be covered .This may include devices, internet connection, school supplies, tutors, or even toilet paper. Some families will need assistance in obtaining and using technology to support the children in their care. Please be creative in considering and supporting this access.

During the Covid-19 Pandemic, foster and kinship support workers and caseworkers are expected to co-ordinate and connect with caregivers AND the children or youths' teachers to ensure their foster and kinship families have sufficient support to participate in their education online. This may include appropriate devices and sufficient internet access for the work expected of the children (i.e. Chromebooks or iPads). Foster and kinship support workers and caseworkers are expected to ask how to help caregivers access what they need.

It appears many schools have some Chromebooks or other tablets to lend, rent or sell to caregivers. Assist caregivers in accessing these devices, especially for lower grades. Rental costs will be covered by CS as an educational expense. Younger children can likely share these in the same home given lighter school demands and with proper sanitizing between users. If a caregiver is unable to access required devices through their schools, one should be purchased for them and claimed by the caregiver as an educational expense. If a caregiver has difficulty paying for the device directly, foster and kinship support workers or caseworkers are expected to arrange for the device to be purchased and provided to the child.

Higher grades or technology-heavy learning may require more robust devices such as full laptops, or even supplementary devices such as headphones, etc. Consider individual circumstances and any special needs in determining the most suitable supports.

Caregivers' Role

Individual school websites or teacher contacts will have the most relevant information for individual students. School division websites may also have important updates. Caseworkers should ensure they are aware of the online learning that is happening for children they are responsible for. Information on the appropriate school division's (authority) contact information and individual schools can be found **here**.

While education may seem like it is a bit lower on the priority list right now, below are some resources for when there is time to focus on education:

- **Telus Internet for Good Program** – helps provide internet access to low-income families.
- **LearnAlberta.ca** - more than 4,000 digital resources aligned with Alberta's K-12 curriculum.
- **My Child's Learning: A Parent Resource** - provides parents with information specific to each grade level.

Further information from the Ministry of Education is available **here**.

Additionally, many Alberta school authorities have a variety of resources available to support parents and students in learning at home. The Edmonton Public Library has **tutoring** available.

Foster and kinship support workers and caseworkers can access the **CI Portal** for a list of available resources for sharing with caregivers.

Caregivers can access the **AFKA website** for a list of available resources for caregivers.

Policy References

Please see **Appendix 1** for policy references related to educational supports.

Financial Support

As per current policy and compensation guides, all caregivers receive financial compensation to care for children in their home. All children in care are additionally entitled to receive further specific financial benefits to support them in their placements, some of which are prescribed and some of which are tied to the particular unique situation for the child and the caregiver.

During the Covid-19 Pandemic, existing policy should be interpreted flexibly in order to assist children and caregivers to address the day-to-day challenges and impacts Alberta Health and Alberta Health Services (AHS) guidelines have on Albertans.

Use the following guiding principles in family based care during COVID-19 as you interpret policy on financial support:

- Stability is important during these challenging times.
- Caregivers and children may require additional support.
- Traditional forms of natural and formal supports may not be accessible or feasible.
- With the requirements on social distancing and schools being closed, respite is a priority for caregivers who care for multiple children with various needs; creativity and flexibility in the provision of respite is a priority.
- Approaches taken to support children and caregivers during the Covid-19 Pandemic are time limited and will not be precedent setting.
- The relationships with foster and kinship support workers and caseworkers are intended to be supportive. In this circumstance with staff potentially off or inaccessible, BOTH foster and kinship support workers and caseworkers can approve and authorize the payment of reimbursement for COVID-19 related supports.

Childcare

Please see the **Childcare section** below for more information.

Recreation Fund

The full recreation fund is available between April 1 and March 31 each year. At this time, recreation that supports children and youth in a foster or kinship care placement may not be what has been traditionally considered appropriate use of the recreation fund. Support

creativity and flexibility in the use of the recreation fund. Examples include the purchase of crafts or yard play equipment to use within the home or back yard.

Additionally, current Policy, including 2.3 Kinship Care Support Plan (Placement Resources) and 3.3.5 Foster Care Support Plan (Placement Resources) supports the ability to cover additional needs outside and beyond the recreation fund including “exceptional recreation”.

Please see the **Caregiver Support Plans** section below. Foster and kinship support workers and caseworkers should work with each caregiver to ensure they have adequate supports.

Camp/Vacation

Given the current uncertainty as it relates to the duration of the COVID-19 Pandemic, it will be very important to remain flexible in terms of the interpretation of all financial provisions. It is very possible that in person camps will not be available this summer; instead workers and caregivers could consider online activities, etc. While travel outside of Alberta is not currently permitted, we should be mindful this may change and opportunities for vacation may be available before the end of this fiscal year.

Remember: Recreation and vacation/camp allowances can also be applied in any combination.

Caregiver Illness and Emergency Situations

Current policy states, in consultation with the caseworker, compensation for child care related expenses, other in-home or placement supports may be provided to caregivers if they must be away from home or are unable to provide care in emergency situations, due to personal illness, sickness or death within the immediate family. Due to COVID-19, there is the possibility caregivers will temporarily be away from the home or unable to temporarily provide care. Should a caregiver become ill, the plan and options will be dependent on the individual circumstances of the caregiver family and must be developed in partnership with the entire casework team based on the best interests of the child. In these situations, compensation for supports such as relief or respite will be provided by CS through a Kinship or Foster Care Support Plan. Please see **Policy Kinship Care: 2.4 Emergency Situations and Foster Care: 3.3.6 Emergency Situations** (Placement Resources). Also see the **Childcare section** below for additional information.

Approved Absences

Current policy indicates kinship and foster caregivers are eligible to receive basic maintenance (as well as skill fees for foster caregivers) during a child or youth’s *approved temporary absence* from the kinship or foster home. Reasons for an approved absence are listed in Policy 3.3.6 Financial Compensation (Placement Resources). **Absences related to COVID-19 will also be considered approved absences.**

Current policy provides for seven days at full basic maintenance and skill fees for foster caregivers followed by seven days at 50 per cent, and seven days at full basic maintenance for kinship caregivers followed by seven days at 50 per cent during an approved absence.

During the COVID-19 Pandemic, the time period for providing full basic maintenance (as well as full skill fees for foster caregivers) during a child or youth's approved temporary absence has been extended to 14 days. This timeframe can be further extended by the caseworker's manager in order to maintain the placement.

Learning Supports

See the **Educational Supports** section above.

Special Rates

Special rates currently in place for foster parents that continue to be supported by the foster care support workers, and where there are no changes, may be extended for a period of three months from April 1, 2020. If all parties do not agree upon the three-month extension or changes to the special rates are required, co-ordinate a teleconference between the foster caregiver(s), foster care support worker, and caseworker to determine what changes need to be made. Follow current procedures for reviewing special rates.

All extensions and new agreements must be documented in CICIO.

Caregiver Support Plans

Any additional supports necessary to maintain a child or youth during the COVID-19 Pandemic must be identified on the Kinship Care Support Plan [**FC3899**] or Foster Care Support Plan [**FC3605**]. In the event the caseworker or support worker is absent, it is important a plan is in place for every child in care and the plan is documented so other caseworkers can ensure a plan is in place to support the child.

Child Maintenance Invoice

To support caregivers and young adults in being reimbursed for funds in a timely manner, the Child Maintenance Invoice has been converted to an electronic form. The Child Maintenance Invoice can be found on the CI Portal **here**. The process for completing and submitting the form for payment includes:

1. The caregiver/young person completes the form, ensuring all relevant fields are filled in.
2. The caregiver/young person emails the completed, electronically signed form and all related receipts and/or approval letters to the caseworker/administrative assistant.
    a. Pictures or scanned copies of receipts/approval letters are acceptable. The caregiver/young person should retain copies of all original receipts.
3. The caseworker/administrative assistant reviews the form and attached receipts/approval letters (pictures/scanned copies) to ensure accuracy. The administrative assistant completes shaded fields, including generating an invoice number (see directions **here**).
4. The caseworker/administrative assistant forwards the electronically signed form and all receipts/approval letters to the casework supervisor/expenditure officer.

5. The Casework supervisor/expenditure officer reviews and electronically signs the completed form, then forwards it to the administrative assistant for processing of payment.

Policy References

Please see **Appendix 1** for existing policy related to financial supports for caregivers.

Childcare

Current policy states foster and kinship caregivers may require resources to provide childcare while they attend appointments, other responsibilities and to allow for breaks from day-to-day demands of parenting. Childcare arrangements may include babysitting, relief, respite and alternate childcare (see **Appendix 2**). Due to the COVID-19 Pandemic, caregivers' access to childcare has become limited or has ceased altogether. The policy-authorized use of childcare has created confusion for staff and caregivers as it appears to conflict with recommendations by Alberta's Chief Medical Officer of Health to practice physical distancing and staying home to decrease exposure.

As a result, the use of childcare is not recommended at this time; other supports for caregivers should be explored. Caregivers are encouraged to stay inside (whenever possible), take all precautions when going out, and try not to use childcare that is not needed.

Caseworker, Kinship or Foster Care Support Worker and Support Network

There may be times, however, when childcare is essential and special consideration is required to support the health and well-being of the child or caregiver.

The child's caseworker and foster or kinship support worker are to pre-plan with the caregiver as well as their support network to identify available options for childcare. Staff will support caregivers who do not have a plan with identifying potential childcare.

Considerations in planning for childcare during the Covid-19 Pandemic may include:

- the caregiver is required to work outside the home;
- the caregiver is working in the home and the children are under school age or not in classes;
- caregiver is unable to care for the child due to attending essential appointments;
- continuation of current respite to support the complex needs of a child in the home;
- relief or respite will prevent the potential breakdown of a placement due to caregiver burnout; and
- contingency planning if a caregiver were to become ill.

When making a plan for childcare, it is important to develop back up arrangements in case the original plan is impacted by illness or exposure of an identified caregiver. Should relief or respite become necessary, the entire team will review the plan with the caregivers to determine if the plan is still current or if adjustments are required.

Families may wish to explore the possibility of partnering with a 'cohort family' if a caregiver family needs to self-isolate due to COVID-19 or COVID-19 symptoms as recommended by Alberta's Chief Medical Officer of Health.

A cohort family consists of:

- Two families who isolate together, not necessarily in the same home, but from everyone else and have limited contact with the outside.
- Families agree to isolate from everyone else but the two families. Both families limit their contact to the outside.
- This can continue as long as both families are healthy, have no underlying health conditions, are not high risk, have no symptoms and have not traveled.

Before the continuation of current respite arrangements OR approving any alternate childcare, consultation with a supervisor is required. Careful consideration should be given to the need for alternate childcare and whether it balances the risk of COVID-19 exposure for children, youth and families. Planning between the child's caseworker, foster or kinship support worker, caregiver and alternate caregiver must identify the protocols required to mitigate exposure risk between the caregiver home and alternate caregiver home.

All staff must follow Alberta Health and AHS guidelines to mitigate risk and caregivers are to report any potential exposure risk. It is essential to follow preventative measures and avoid contact with others who have COVID-19 symptoms and have travelled outside Canada, or were exposed to someone who has confirmed COVID-19.

Documentation

In addition to documenting on a contact log, the resulting COVID-19 related plans must be recorded in CICIO in special cautions.

Enter a special caution for planning childcare options and temporary placements needed due to COVID-19. Please review current special cautions placed on the system and end date any that no longer apply in order to ensure all special cautions are current.

The impact of COVID-19 requires flexibility in our approach to alternate childcare and supporting caregivers. Below is a chart outlining current policy and COVID-19 adjusted practice. ***Any childcare arrangements*** must be discussed with child's caseworker as well as foster or kinship support worker and approved by a supervisor.

Policy References

Please see Appendix 2 for existing policy related to childcare supports for caregivers.

Additional Information

Travel

All prior approved international and provincial travel is suspended. If there are exceptional circumstances to be considered, please elevate those requests to the Office of the Statutory Director through your regional director.

Attending Funerals and Wakes

For information regarding attending funerals and wakes, please see "**Attending Funerals and Wakes**" under "**Contact and Communication**".

Appendix 1:

Existing Policy Supports for Children in Care

Policy	Purpose	Staff Role During Pandemic
2.3 (Placement Resources) Kinship Support Plan [FC3899]	MANDATORY! Initial and on-going supports assist kinship care providers in meeting the needs of children placed in their homes; ensures kinship care providers have any supports they may need to successfully care for the children.	Complete a collaborative assessment with the kinship caregiver and child's case team to identify COVID-19 related support needs and include them on the kinship support plan. Review if circumstances change. Form FC3899: Check "Other" under "Situation" and write "COVID-19" in the line below. Include details of the situation requiring the kinship support plan. Include details of supports required under "Support Services".
2.4 (Placement Resources) Kinship Financial Compensation	Financial compensation to care for children in their home; every child is unique; caregivers may be compensated for *other needs* that *may arise* that are consistent with the care of the child; child *entitlements*.	Additional Supports: Use the listed compensation and entitlements *plus* there is extensive flexibility in addressing factors that could become a barrier to caring for a child. Please consider the guiding principles. Special Costs: exceptional expenditures; caseworker consultation required
3.3.5 (Placement Resources) Foster Care Support Plan [FC3605]	A foster care support plan applies when there are …*exceptional circumstances* of a foster home to help provide foster parents with *the supports necessary to meet the needs of children in their care.*	Foster care support plans require the approval of the caseworker's supervisor; however, it is expected that such approval will not be unreasonably withheld and will be exercised in a manner enabling the provision of the right services to maintain the child's well-being. Use the principles outlined at the

Policy	Purpose	Staff Role During Pandemic
		beginning of this document as a guide. Form FC3605 - Check "Other" under "Situation" and write "COVID-19" in the line below. Include details of the situation requiring the foster care support plan. Include details of supports required under "Support Services".
3.3.6 (Placement Resources) Foster Care Financial Compensation	Financial compensation to care for children in their home; child *entitlements*.	Additional Compensation: equipment or supplies to facilitate or support placement Special Costs: consider exceptional expenditures; caseworker consultation required
Policy 9.2 (Intervention) Education	Accessing appropriate educational programming that meets the child's needs.	Collaborate with Education and caregiver partners to develop a plan and advocate for appropriate programs and supports. This will include ensuring caregivers have access to all additional technology and any other additional support (i.e. tutoring support). Required supports can be claimed as educational expenses.

Appendix 2:
Existing Childcare Policy Supports for Children in Care and Modifications During the COVID-19 Pandemic

Policy 3.4 (Placement Resources) Child Care Arrangements for Caregivers

Child Care Options	Babysitting	Relief	Respite	Alternate Child Care	Modified approach during COVID-19
Reason	Short-term care (not overnight).	Caregiver away for an extended period of time.	Provided to caregivers caring for children with complex needs or for exceptional circumstances of a caregiver.	Caregivers who work out of the home or attend school and have alternate child care providers (e.g. nannies) who relate to the child in a parenting capacity. Note: This does not apply to licensed childcare providers (e.g. day care, family day home etc.) as defined under the *Child Care Licensing Act.*	Need for respite and identified as essential (ex. set up prior to COVID-19 and ongoing). Risk of caregiver burnout (need a break). Caregiver is temporarily unable to care for the child. Caregiver or family member is sick or tests positive for COVID-19.
Duration	Up to 12 hours on any one occasion; usually occurs in the caregiver's home.	Overnight, weekend, a week at a time.	As outlined in a support plan.	Regular and ongoing basis.	As required and discussed with the child's caseworker and foster and kinship support worker.
Safety Checks	Caregivers hire babysitters at their discretion, considering the maturity, skill level and experience of the babysitter as well as the number and special needs of the children.	An Intervention Record Check (IRC) is required for the relief care provider as well as any additional information requested by the caseworker.	Must be provided out of the caregiver's home by licensed foster parents or residential facilities. Caregivers must provide the caseworker's contact	A Criminal Record Check (CRC) with Vulnerable Sector Search and an IRC. The foster and kinship support worker or caseworker will conduct face-to-face interview of the childcare provider.	**Must** follow Alberta Health and AHS guidelines to mitigate the risk. AHS Screening IRC as per current practice CRC as per current practice. See CI practice

Child Care Options	Babysitting	Relief	Respite	Alternate Child Care	Modified approach during COVID-19
	The babysitter must be able to reach the caregiver in the event of an emergency.	Caregivers must provide the name, address and contact information of the relief care provider, the dates the child will be in relief care, and the names of any other persons in the relief caregiver's home to the caseworker and foster and kinship support worker.	information to the caregiver for emergency use, in addition to the caregiver's contact information.	Caregivers must provide the caseworker's contact information to the alternate caregiver for emergency use, in addition to the caregiver's contact information.	guide for further information. Caregivers must provide the name, address and contact information of the childcare provider, the dates of childcare, and the names of any other persons in the alternate caregiver's home to the caseworker and foster and kinship support worker.
Compensation **See Compensation Guide - For Foster and Kinship Caregivers for further details.**	Babysitting will be reimbursed as per the Caregiver Rate Schedule [FC1263] For any other reasons, caregivers compensate the babysitter.	Automatic Relief/Respite: As per the Caregiver Rate Schedule [FC1263], caregivers will be reimbursed for two days a month for each child placed in their home and can bank up to six days to be used at one time. Prior approval is not required. Relief care will be reimbursed as per Caregiver Rate Schedule [FC1263] if it is for mandatory training or other business related to caregiving. If there are exceptional circumstances of the home, regular relief or respite may be included and reimbursed through a support plan. For any other reasons, caregivers compensate the relief caregiver.		Caregivers compensate alternate childcare, or may have costs included in their support plan.	**Automatic Relief/Respite**: Due to potential need for further relief/respite after the COVID-19 Pandemic, a caregiver can bank up to 12 days to be used at one time. Prior approval is not required. If a caregiver is sick due to COVID-19 and requires **relief/respite,** see Policy 3.3.6 Emergency Situations (Placement Resources). As per CI Practice Guidance: Coronavirus (COVID-19), caregiver will be reimbursed for **alternate child care** arrangements with NO

Child Care Options	Babysitting	Relief	Respite	Alternate Child Care	Modified approach during COVID-19
					PREAPPROVAL REQUIRED.

Click **here** to return to the Table of Contents.

Links:
Child Maintenance Invoice Form

Date Released:	Date Updated:
March 31, 2020	April 16, 2020

GROUP AND CONGREGATE CARE

As the situation unfolds, more information will be forthcoming as it relates to support group and congregate care.

As of March 16, 2020, all worksites as well as group care and residential facilities are being asked to limit onsite guests to ***essential visitors only***. We are also asking all offices and facilities to post signage at entrances and reception. Signage can be accessed on the **AHS'** website.

All staff, children and essential visitors must be screened before being allow entry into the facility, including youth returning from and absence without permission, by using the Health Assessment Screening Questionnaire.

Ask questions about recent travel, close contact with anybody who is ill and any symptoms they may be experiencing. Please note any underlying/chronic health conditions that may make them more susceptible to severe COVID-19 symptoms.

All group care providers are to be practicing social distancing and limit participation in social events or clubs.

If a child has been absent without permission, screen them upon their arrival.
If you suspect a child or staff person is ill, has or has been exposed to COVID-19:

- Please immediately go to Alberta Health Services' (AHS) website for the most current instructions.
- You will be asked to complete a self-assessment and follow the instructions once completed.
- If required to isolate a child or self- isolate, follow the directions from AHS. These might be tailored to your specific situation.
- Document all direction received.
- Communicate these directions and instructions to your staff.
- Identify what, if any, additional supports are required.
- Implement instructions received.
- Call and report the situation to the caseworker and/or contract manager and inform them of any next steps directed or recommended by AHS.

If a child who requires isolation refuses to stay at a facility, please contact the worker immediately.

Please refer to the COVID-19 Facilities Guide for more detailed information.

Expiring Residential Facilities Licences

Licences that are expiring can be extended for a period of up to three months. If you believe your agency falls into that category, please contact your licensing officer.

Criminal Record Checks

For information regarding obtaining Criminal Record Checks for agency staff, please see **"Criminal Record Checks".**

Intervention Record Checks

For information regarding obtaining Intervention Record Checks for agency staff, please see **"Intervention Record Checks".**

Click **here** to return to the Table of Contents.

Date Released:	Date Updated:
March 31, 2020	April 16, 2020

STAFF SAFETY

The Ministry of Children's Services takes employee safety very seriously. During the COVID-19 Pandemic, we are instituting even stronger measures to help you stay safe.

We continue to provide updated **practice guidance** on a daily basis or as needed. Please ensure you continue a routine of regularly reviewing that document for important changes. While employee safety guidance is embedded into the practice document, given the critical importance of this topic and for ease of reference, this information is also now being made available as a standalone document, and will be updated as changes occur.

For employees who work in group care [YYC and YAC] please also go to this link COVID-19 Facilities Practice Guidance.

Workplace – Offices and Work Sites

As you know, Child Intervention offices are closed to the general public for the duration of the pandemic.

- **DO NOT** go to work when you have symptoms, and self-isolate for the timeframe set out by Alberta Health and Alberta Health Services (AHS).
- Promote good personal hygiene and workplace cleaning practices.
- Keep frequently touched common surfaces clean (telephones, computer equipment, etc.).
- Enforce social distancing (work spaces are separated, no shaking hands, limit the number of people meeting in one space/room).
- Work from homes strategies are in place. Work with your supervisor and manager to discuss the unique needs of your worksite and community.
- Although employees enjoy sharing food and treats, in this current climate please refrain from bringing in food to share with others, and remove treat or candy dishes. If you bring items to the workplace in containers that are recyclable, please take them home with you rather than disposing of them in the office recycling bins.
- Although the public is not permitted in our worksites at this time, under special circumstances, children and families may be welcomed into designated areas of our worksites. When doing so, they should remain in one room large enough to ensure a two meter distance between participants. If you are unsure, please speak with your supervisor or manager about which space is designated for this purpose.

In-Person Visits - Family/Assessment Visits, Meetings, Transporting, Case Conferences

Effective immediately, in-person visits **should no longer occur** for regular, ongoing case management activities. The Child Intervention Practice Standards regarding face-to-face contact are currently suspended; however, it is important to maintain ongoing contact with children and families you are working with.

In-person visits should continue for urgent matters that require immediate attention at intake, assessment or special circumstances that arise during ongoing case management (court-ordered access, etc.). These circumstances must always be discussed with your supervisor in advance.

- Under no circumstances should you go on visits or be at work when you are feeling sick, have symptoms or have been advised by AHS to self-isolate.
- Prior to a visit or in-person meeting, conduct a screening (phone, email or in person) using the screening questions outlined in the Practice Guidance Document.
- **DO NOT** enter a home or have an in-person interaction where someone has symptoms of COVID-19.
- Social distancing (two meters, no shaking hands, limit the number of people meeting) must be followed during interactions.
- Immediately wash your hands with soap and water, or use hand sanitizer, after any meeting or in-person interaction.
- If you have to lift, move or touch a child or youth, wash your hands with soap and water or use hand sanitizer after the interaction has ended. Follow this procedure after every interaction.

Personal Protective Equipment (PPE)

There have been many question regarding the use of PPE in our daily work with children, youth and families. To be clear, we do not expect delegated workers or administrative employees to interact with an infected or symptomatic person; therefore, the use of PPE is **NOT** required. Alberta Health and AHS have clear guidelines on using PPE, which are provided below.

Wearing Masks

Wearing a mask can be very important in certain situations. Alberta Health and AHS advise if you are sick, wearing a mask helps prevent passing the illness on to other people.

The Chief Public Health Officer of Canada has recommended the use of masks for all individuals when outside of their home. This includes staff who must meet with clients. It is important to note the use of masks recommended include all masks, including fabric masks.

It is important that when putting on and taking off a mask, you are following proper precautions. According to the World Health Organization, the following outlines how to properly wear and dispose of a mask:

- Before putting on a mask, clean hands with hand sanitizer or soap and water (for at least 20 seconds).
- Cover mouth and nose with mask and make sure there are no gaps between your face and the mask.
- Avoid touching the mask while using it; if you do, clean your hands with hand sanitizer or soap and water (for at least 20 seconds).
- Replace the mask with a new one as soon as it is damp and do not re-use single-use masks.
- To remove the mask: remove it from behind (do not touch the front of mask); discard immediately in a closed bin; and clean hands with hand sanitizer or soap and water (for at least 20 seconds).

Extensive Use of PPE

Where employees' duties require them to come in close contact with individuals who may be infected (e.g. residential care settings), PPE usage should follow Alberta Health Guidelines and associated Point of Care Risk Assessment (PCRA) for the use of:

- Surgical masks
- Gowns
- Eye protection
- Gloves

If you are an employee working in a congregate care facility, please see the COVID-19 Facilities Practice Guidance for detailed instructions on the proper and appropriate use of the different forms of PPE.

Alberta Health and AHS guidelines should be consulted on a case-by-case basis, as recommendations can change.

Click **here** to return to the Table of Contents.

Links and Forms
COVID-19 Reporting Form
Alberta Health Screening Questionnaire
COVID-19 Facilities Practice Guidance

Updated

Date Released:	Date Updated:
April 22, 2020	April 29, 2020

CHILD AND YOUTH SUPPORT (CYS) PROGRAM

Private Child Care Costs

Licensed daycares and schools are closed due to COVID-19 and some CYS clients have to use private childcare instead.

Effective immediately, during the COVID-19 pandemic the monthly maximum of private child care is increased from $300 to $546 per child (for children up to grade 6). This correlates to the current maximum approved for a toddler in a licensed day care facility. The total monthly cost paid must correlate to the hours of childcare provided. The hourly rate is $3.00 and the daily maximum is $25.00.

The CYS program will allow the private childcare costs to be paid to relatives of the child or caregiver during the COVID-19 pandemic. Relatives include the following: grandparents, parents, uncle, aunt, niece, nephew, cousins, siblings, in-laws, step-parents or any of the above created through adoption.

The parent/guardian of the child must agree to the use of private child care services by signing the Authorization for Private Child Care form [CDEV3656]. Caregivers using private childcare are required to submit receipts and the Private Child Care Receipt Verification form [CDEV3657] each month to claim for child care benefits.

When looking for a private childcare provider, CYS caregivers can go to Finding Quality Child Care and Childcare during COVID-19 for more information.

Payment Process

To process the payments for private child care cost, enter up to the maximum amount of $300.00 under Private Child Care. For the amount above the $300.00 maximum up to $246.00, this will be entered under Benefit from Administrative Review.

The CYS Program Coordinator needs to maintain a spreadsheet that captures these additional costs and send it to the Regional Finance Budget Officer on a monthly basis. Regional Finance will ensure a journal entry will be processed, transferring the additional costs to the COVID-19 Prevention Program Code 34002.

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CI Practice Guidance:

Coronavirus (COVID-19)

Date Released:	Date Updated:
May 29, 2020	May 29, 2020

A Staged Approach to In-Person Work for Child Intervention Practitioners and Agency Partners

Albertans have done a tremendous job adhering to the guidance that has been provided by the Chief Medical Officer of Health to manage the COVID-19 Pandemic. Child Intervention Practitioners have been a significant partner is helping manage spread and keeping children and families safe.

Alberta is now at a place where gradual resumption of activities and reopening of businesses and services is underway. This doesn't mean that the threat of COVID-19 has disappeared; rather that the spread of this virus has been slowed down, which will allow time for a vaccine to be developed. Until that time and for the foreseeable future, Albertans will need to continue to operate in a 'new normal' way and:

- Demonstrate Vigilance to slow the spread
- Follow public health measures
- Practice physical distancing
- Practice good hygiene
- Use personal protective equipment in certain situations

Casework Relaunch

The health and safety of Child Intervention Practitioner's (CIPs) and of our agency partners has been vital and will continue to be so as Children's Services and partners move forward through the COVID-19 pandemic. By utilizing a staged approach towards the "new normal" in providing services to children, youth and families, we are continuously improving. As public health measures are modified, CIPs will transition into the next stage of our work, including continued collaboration with community partners and DFNA's. It is important for different regions of Children's Services to connect with First Nations Designates and DFNAs during this time to support connection for Indigenous children.

Throughout the staged approach process CIPs and agency partners will continue to ask initial screening questions and follow AHS and Practice Guidelines. And to support CIPs/staff, Personal Protective Equipment (PPE) will be required for the safety of

families and workers while phasing back into working directly with families in the community. Children's Services will supply all required PPE to CIPs.

CIPs will review the Field Level Hazard Assessment with their supervisor prior to resuming field work. **Agency partners will have their own safety hazard assessments to complete based on their OHS guidelines.**

Once supervisors have confirmed CIPs have reviewed the Field Level Hazard Assessment CIPs can immediately proceed with in person and face to face work. By June 7th, all CIPs are expected to be conducting home visits and face-to-face visits with children, parents and guardians. As things continue to evolve with the COVID-19 response, CIPs will be asked to be creative with the incorporation of technology while ensuring that they are also completing face to face as necessary.

Things to consider in preparing to resume in person contact:

- You **must** have completed the Staff Safety and PPE Checklist and the Hazard Assessment specific to your role BEFORE resuming in person contact.
- Face to Face/in person contact isn't necessary for all casework all of the time– the use of virtual connection has been extremely successful and so should be utilized to supplement face to face.
- Approach face to face and in person contact with children, families and caregivers in a way that demonstrates appreciation for the anxiety and concern families may have. This could include offering to wear a mask to make the child or family feel more comfortable and using/creating environments where physical distancing is easily managed.
- In person and face to face does not necessarily always mean in the home. These decisions should be made in collaboration with the child, youth family and/or caregiver and based on the need to physically enter a premises.

Stage 1 (May 25- June 7)

During Phase 1, CIPs (CASEWORKERS/ASSESSORS) in collaboration with agency staff will consider which files they will be responding to as a priority.

CIPs/agency partners will begin to conduct home visits and face-to-face visits for non-urgent matters. Using the scaling questions in the Practice Guide and in consultation with your supervisor, determine which specific children and families you will be seeing in person. Manager consults should continue when a CIP/agency partners is attending a home where, based on the responses to the screening questions, COVID-19 may be present. Agency partners will conduct their own screening as well in line with their OHS guidelines and in the event that both CIP and agency staff are attending a home together, determination will need to be made as to whether the CIP or agency staff will be completing the screening questions. If a person in the home is known to be COVID-

19 positive or they have had close contact with someone who is, the CIP or agency staff that becomes aware of this will report this to others who may visit the home. If a person in the home is known to be COVID-19 positive, do not enter the home and consult manager (supervisor) for further guidance.

Stage 1 includes the following priority categories of files:

Children 6 Years Old and Under

Children under six are the most vulnerable population that we serve. They are not attending school, cannot speak for themselves, are unlikely to be able to individually access technology or have the ability to connect to family or other support networks on their own. The use of technology and virtual assessment for these children as a continued matter of course is not always reliable and may leave them at further risk. Children under 6 must be seen in-person.

Medically Fragile, Severe Neglect and Unexplained Injuries

Children who are medically fragile or are reported to be exposed to chronic and severe neglect, as well as children with unexplained serious injuries whose parent(s) or guardian(s) are in denial of the injury and/or who have unexplained serious injuries from an unknown perpetrator, **need to be seen on a priority basis.**

Non-responding Families with Open Files under CYFEA

Despite our best efforts, not all families have responded to caseworkers attempt to communicate with them during the COVID-19 Pandemic. c. Some have not had access to sufficient technology, may have had to relocate or have been unresponsive for various other reasons. Due to these unsuccessful attempts to connect with these families, they **must be seen in person to assess current level of safety and risk and case plan and offer supports accordingly**.

High Risk Youth

During the COVID-19 health crisis, High Risk Youth may have lost connection with their CIPs and other family and support networks. They have often become more isolated as they have been limited in their ability to access mental heath supports, shelters, and even hot meals. In some instances, their access to technology was also interrupted or disappeared. They are at high risk for exploitation and so **in person reconnection with caseworkers is required**.

Those with Expiring/Renewing Agreements (Families/Youth and SFAAs)

Children and families remain vulnerable at home during the COVID-19 response, especially since children are not attending school and there may be limited access to family or support networks and may require further supports beyond what the original case plan had contemplated. We need to ensure that needed supports continue to be in place to prevent loss of safety, so **these children, youth and families need to be seen in person.**

Families with Supervision Orders

Although we have been completing face to face visits with children and parents using technology, seeing them from afar over FaceTime and Skype etc., it does not negate the need to be meeting with these families in person. We must ensure that we are adhering to court ordered terms. **In-person attendance at the homes of families with Supervision Orders is now required** (does it need to be in the home?)

Family Time

Family Time is essential to the children and youth in our care and for those children who are in the midst of reuniting with their families. Where possible, collaboration with their supervisor, case team and family network, the CIP/agency partner will need to make arrangements for in-person visits with children and their families while following the AHS and CS Practice Guidelines. CIPs/agency partners will prioritize visits with children and families who, prior to COVID 19 were in the process of reunifying and where technology has not been able to support ongoing contact (infants and toddlers). The focus will be on connecting children with families as much as possible being as creative as possible, visits outside, support networks involvement, in ways that maintain physical distancing. Alternating in person visits with Skype/FaceTime etc. is also acceptable.

CIPs/agency partners will not be completing face to face visits with children who are in foster homes in Step 1 unless absolutely necessary. This will help reduce the number of people coming and going into the foster homes and group care.

Stage 2 (Beginning June 7)

Throughout stage 2 you will gradually return to standard practices. Using the scaling questions in the Practice Guide and in consultation with your supervisor and manager, you will jointly determine which files you are attending to on an in-person basis.

Family Enhancement Agreements where contact with the family has been maintained during COVID -19 using virtual means

Technology such as Skype and FaceTime has been extremely useful during the COVID-19 Pandemic. We need to be meeting with these families in–person, to continually assess the parent's willingness and ability to ensure their children's safety. During this stage, Family/ Support network meetings can resume while following the AHS and Practice Guidelines.

Support and Financial Assistance Agreements

Young people may not have been able to access support and the resources required for them to successfully transition to adulthood during the COVID-19 pandemic. Young people who are aging out and are transitioning to adult services may require guidance and support to aid them in their transition. **In person contact must be made with SFAA recipients where possible.**

Family time Continues

Family time is essential to the children and youth in our care. Where possible CIPs/agency partners in consultation with their supervisor, case team (including caregivers in foster home) and family network will need to make arrangements for in person visits with children and their families while following the AHS and Practice Guidelines. (See Family Time Practice Guidance)

In Person Contact with Children in Care

Mandatory Face to face with children in care in their placements will resume. This means that delegated workers will begin to approach placements to conduct the required face to face contact with children, both alone and with caregivers as appropriate. Measures to maintain safety will be discussed with the placement in advance.

CIPs need to initially connect with the Foster and Kinship support workers who can assist in the coordination of in person visits with caregiver's both within and outside of the caregiver's home, to minimize the number of people coming and going at one time.

CIPs/agency partners should be aware there may be additional precautions or expectations when visiting caregivers' homes and/or group care settings, like wearing a mask or having you temperature taken with a non-invasive infrared or similar device.

Family/Support Network Meetings, Band Consults

Continuing to support families and maintaining connections with family is a critical piece of life long connections. This will need to be done in accordance with the AHS and CI Practice Guidelines. Some of these meetings may continue to proceed using technology, however efforts should be made to consider some in person meetings where social distancing can be practiced.

Regional, Inter-Regional File Transfers

Not all families that we work with remain living in the same home, area, town/city or even the same part of the Province, and therefore will require their files to be transferred to other offices or regions.

Date Released:
May 29, 2020

Date Updated:
May 29, 2020

FAMILY VISITS FOR CHILDREN IN CARE

As the province moves into a phased relaunch, Children's Services will need to gradually resume normal legislative activities in a way that is safe and ensures the best interests of children in care remains a priority.

Family time is recognized as a key strategy for children to foster healthy connections, bonds and attachments with their parents/guardians/siblings. To date CI Practitioners, agency partners and caregivers have played a significant role in keeping children safe and helping manage the spread of COVID-19. Continued collaboration will be instrumental in the process of reinstating in-person family visits, and as we continue to navigate this 'new and normal' way of meeting children's needs.

Planning for an in-person visit between a child in care and their parent is made in collaboration with the CI Practitioner, their supervisor, the child's parents, caregivers and involved agency partners. In-person visits may be supervised or unsupervised in accordance with the case plan. Regardless of circumstances they must be in accordance with AHS guidelines. For children in care the reference to **parent** throughout the document may be replaced with **a sibling or another significant person**.

During this time of transition, CI Practitioners, agency partner and caregivers will need to utilize information gathered through collaboration to make the most reasonable case planning decisions possible. While there are multiple considerations to balance, the outcome measure remains safe, healthy, and connected children and families.

Considerations for an In-Person Visit

When an in-person visit is being considered, the following measures will be addressed to decrease the risk to the child, the parent and any child placement resource:

Screening

The parent, child, and child placement resource using the Screening Tool provided by AHS.

This screening is required for each face-to-face visit and for everyone in attendance.

If a child or a parent have been ordered to self-isolate, an in-person visit will not be considered for the period of self-isolation.

Capacity of the Parent and Child to Adhere to AHS Guidelines and Supports Required

Prior to an in-person visit, the CI Practitioner and case team including agency partners and the child's network will assess the capacity of the parent and of the child to adhere to the guidelines set out by AHS. The following questions will be considered:

- What is the ability and commitment of the parent and of the child to maintain safety during the visit?
- If the parent or child's capacity is limited, what supports can be provided to assist the family in adhering to the guidelines?
- Do the parent and child comply with AHS guidelines outside the visit?
- As long as safety can be maintained the benefit of in-person connection and contact for the child should be prioritized, meaning that networks should consider alternate environments, various types of visits and creative strategies prior to denying an in-person visit.

Supports for the Caregiver

The health and safety of the child, placement resource, as well as that of other members of the home, must be considered. Caregivers should be involved in the discussions and have the opportunity to express their needs, as well as provide feedback and observations.

Select a Location

The location and activities should allow for physical distancing of 2 meters (6 feet), for example, an outdoors location or a government or agency office (e.g., interview room). If a government or other office is used, hard surfaces will be cleaned appropriately (sanitized) both before and after the visit. This will include phones and electronics, if present.

Develop a Visitation Plan

The case team and network will develop a clear visitation plan that includes how the risks for COVID-19 exposure will be reduced. This visitation plan should include measures to decrease risk and promote infection protection, including limiting both the number of people in the visit and the length of the visit.

Documenting the Visitation Plan

The visitation plan is to be created with both the CIP and the agency staff and is to be documented on a contact log in CICIO indicating when and how it was shared with the parent and their agreement with the plan and entered in to CICIO under the visitation

plan tab named COVID-19 visitation plan. The visitation plan should be shared with agency staff.

Prior to Each Face-to-Face Visit

Assess the Current Risk of COVID-19 for the Visit

If there is an increased risk (such as presence of symptoms, travel history or known exposure to a confirmed COVID-19 case), postpone the visit.

Location

Follow the measures for cleaning and disinfecting the meeting spaces contained in the Practice Guidance.

Monitor General Precaution Adherence

Monitor adherence to Alberta Chief Medical Officer of Health guidance on general precautions (physical distance, hand hygiene, cough etiquette).

Be Prepared with Personal Protection Equipment (PPE)

Ensure PPE supplies (mask and alcohol-based hand sanitizer) are available during the visit in the event they become necessary (e.g., someone begins to display symptoms during the visit). If any health or safety concerns arise for any individual during the visit, the visit should be ended without unnecessary delay.

Child in Care or Parent Living Outside of Alberta

When a child in care or a parent live outside the province, maintaining contact through alternative measures such as video calls, phone calls and texts is recommended. Out of province travel is currently not permitted for children in care. *If an in-person visit is essential, please elevate the request to the Regional/DFNA Director who will follow the process for exceptional travel out of province.*

Date Released:	Date Updated:
May 29, 2020	May 29, 2020

TIPS FOR ENGAGING FAMILIES WHEN WEARING PPE

Wearing PPE can be scary for both kids and adults. If you can, warn people ahead of time that you will be wearing PPE.

1. Have a proactive conversation with the family about COVID-19.

Check out what caregivers know and have told children about the virus.

Top Tip: Consider using this resource (it's available in lots of languages!) to help children understand what all this means: **#COVIBOOK**

2. Why are you wearing PPE?

Let people know that you wear it to all your visits now to help keep families from getting sick and that it is changed after each visit.

3. Let people know you don't usually wear PPE and it feels awkward for you too. Acknowledge that it can make people look scary.

Top Tip: Consider putting a smiley, prominent picture on the outside of your gown/clothes to accompany your ID badge so people can 'see' who they are talking to. Even people that have met you before might not recognize you with PPE.

4. Assure people that you can still do your job.

Top Tip: Remember to still smile! How you feel shows on other parts of your face even if your mouth is covered up. Be expressive: body language matters even more now.

5. Find creative ways to summarize your visit.

Top Tip: Draw pictures and leave a business card in case there are questions.

Double check – ask families what they have heard and what they understand. Some people rely on lip reading to help with communication.

The following resources can be watched or shared with families to explain the new way of visiting:

- **PPE (for Kids)**
- **Physical Distancing (For Kids)**

CI Practice Guidance:

Coronavirus (COVID-19)

Tips for Working at a Distance

- Physical distancing is an important infection control strategy to keep people from getting sick. Whenever possible stay 2 metres (6 feet) from others.
- Limit the amount of people going into a space to those who are absolutely required. Consider connecting virtually to others during the visit.
- Use PPE when physical distancing cannot be assured.
- Make a conscious effort to plan in advance if you are attending a home with others.
    - Discuss who will stand where and ask for reminders from your colleagues when you are engaged in the visit – it is possible you will forget!
- It can be challenging to employ physical distancing practices in small spaces.
    - Where possible and if privacy and weather permits, discuss with the family whether meeting outside could work.
- Explain the importance of physical distancing to the people you are visiting so they understand why you are keeping your distance.
    - This is public health direction to help stop the spread of COVID-19 and helps maintain the safety of everyone.
- Identify and discuss with the family where in the house you are going to place yourself to conduct interviews/make assessments.
    - Ask those that do not need to be in the room to go elsewhere in the space for the duration of the visit if possible.
- We are not used to being physically apart from people in our work. Feeling discomfort or awkwardness is normal.
- Be mindful – fear and mistrust of the medical system (and child welfare) expressed by racialized and marginalized individuals, including those experiencing mental health issues, may be amplified by a child welfare worker wearing equipment typically reserved for the health care field.

COVID-19 INFORMATION

GUIDANCE FOR MULTI-FAMILY DWELLINGS, CONDOMINIUMS AND APARTMENT BUILDINGS

Overview

This document has been developed to support owners/landlords in reducing the risk of transmission of COVID-19 among residents, guests and workers in multi-family dwellings, condominiums and apartment buildings. Public health orders by the Chief Medical Officer of Health, particularly Order 18-2020 and Order 19-2020, require that the operator of these locations comply with these guidelines as much as possible.

COVID-19 Risk Mitigation

Supporting Safety of Residents & Visitors	• Use posters to remind residents and visitors (e.g., guests, delivery persons, repair persons) of the importance of preventing the spread of COVID-19. • Encourage residents and visitors to wash their hands or use hand sanitizer with at least 60% alcohol content when entering and leaving the premises, particularly if they must pass through common areas accessed by other residents and visitors. • Remind residents of gathering and physical distancing requirements.

Entryways & Common Areas	• Enhance cleaning protocols and prevent gatherings in common areas.
	  ○ Common areas are those accessed by multiple residents or households, repair and maintenance persons and include social rooms, lobbies, patios, laundry rooms, bathrooms, recreation rooms, storage rooms, hallways and stairways.
	  ○ Pay particular attention to cleaning of doorknobs, light switches, stair railings, elevator buttons, laundry machine controls, and other high touch surfaces.
	• Encourage limited elevator use to ensure that a two-metre distance can be maintained in the elevator, unless occupants are from the same household.
	• Remove communal items that cannot be easily cleaned, such as brochures, newspapers and magazines.
	• If common seating areas exist, arrange seats to facilitate physical distancing. Consider removing seats to discourage gathering.
	• Remove self-serve amenities such as water coolers, coffee stations, and lobby snacks.
	• Provide hand sanitizer stations, in particular near entrances and exits.

GUIDANCE FOR MULTI-FAMILY DWELLINGS, CONDOMINIUMS AND APARTMENT BUILDINGS

Recreational Areas	• Public and resident access to social and recreational amenities, such as swimming pools, hot tubs, steam rooms, fitness facilities, multi-purpose and games rooms remains prohibited. ○ To preserve water quality, it is strongly encouraged that pools be maintained in accordance with Alberta Pool Standards while closed to public access.

COVID-19 INFORMATION

GUIDANCE FOR OUTDOOR EVENTS

Overview

Under current Chief Medical Officer of Health Orders, businesses and entities are required to:

- implement practices to minimize the risk of transmission of infection among attendees;
- provide procedures for rapid response if an attendee develops symptoms of illness;
- ensure that attendees maintain high levels of sanitation and personal hygiene;
- comply, to the extent possible, with the COVID-19 General Relaunch Guidance, this guidance, and any other applicable Alberta Health guidance found at: https://www.alberta.ca/biz-connect.aspx.

This document has been developed to support those who organize outdoor events, such as weddings, family reunions, retirements, anniversaries, volunteer appreciations, or other celebrations, in reducing the risk of transmission of COVID-19 among attendees (including workers, volunteers, patrons and the general public). The guidance provided outlines public health and infection prevention control measures, specific to these settings or activities.

This document and the guidance within it is subject to change and will be updated as needed. Current information related to COVID-19 can be found: https://www.alberta.ca/covid-19-information.aspx

COVID-19 Risk Mitigation

General Guidance	The maximum number of individuals permitted at an outdoor gathering is 100.
	• The outdoor gathering limit includes all individuals who are present at the outdoor event, and includes caterers, wait staff, photographers, performers and musicians that may be present.
	• Encourage and facilitate attendees staying up to date with developments related to COVID-19.
	• Notify attendees of the steps being taken to prevent the risk of transmission, and the importance of their roles in these measures.
	  ○ COVID-19 signage should be posted in highly visible locations:
	  ▪ "Help prevent the spread" posters are available.
	  ▪ When possible, provide necessary information in languages that are preferred by attendees.
	• All Albertans must follow CMOH Order 05-2020, which establishes legal requirements for quarantine and isolation.
	  ○ Anyone with symptoms of COVID-19 must remain at home.
	  ○ Organizers should develop a plan to provide isolation for an attendee if needed.

GUIDANCE FOR OUTDOOR EVENTS

	As all international travellers must quarantine for 14 days upon entering Canada. International travellers must plan ahead to ensure they can complete their quarantine prior to attending a gathering. Consider if virtual attendance is possible for individuals who are at increased risk for more serious illness after contracting COVID-19, such as the elderly or people who have pre-existing health conditions or are immunocompromised. Infants and children should remain with their parents or guardians at all times. To support public health contact tracing efforts in the event that an attendee tests positive, organizers should consider collecting the names and contact information of attendees. • Providing information is voluntary for attendees. An organization must obtain an individual's consent and notify them about the purpose and legal authority for the collection. • Information about attendees will only be requested by Alberta Health Services if a potential exposure occurs onsite. • For businesses/workplaces, this includes staff, workers and volunteers on shift. Where feasible to do so, and particularly for personal services and group events, it should also include patrons/customers/the general public. • Records should only be kept for 2 weeks. An organization must make reasonable security arrangements to protect the personal information. • Any personal information that is collected for COVID-19 contact tracing can only be used for this purpose, unless an individual provides their consent. • For more information, the Office of the Information and Privacy Commissioner has released Pandemic FAQ: Customer Lists about collecting personal information from customers during the COVID-19 pandemic. • For questions about your obligations under PIPA, please contact the FOIP-PIPA Help Desk by phone at 780-427-5848 or by email at sa.accessandprivacy@gov.ab.ca.

Screening & Response Plan	Organizers should:
	• Post signs that instruct those who may have been exposed to COVID-19 to not enter.
	• Consider implementing active screening of attendees (where applicable) and staff for symptoms of fever, sore throat, cough, runny nose or difficulty breathing.
	  ○ The Alberta Health Services COVID-19 Self-Assessment tool can be used by attendees.
	  ○ Organizers may choose to use the daily checklist found in the COVID General Relaunch Guidance document.

GUIDANCE FOR OUTDOOR EVENTS

	A rapid response plan sets out a fast-action plan for organizers when an attendee shows symptoms of COVID-19.
	• Organizers should develop a plan that includes appropriate policies and procedures based on the type of attendees specific to their services and settings.
	• Attendees should be familiar with and follow the organizer's rapid response plan if an attendee starts feeling symptoms during a shift. This should include:
	  ○ Immediately isolating the attendee from others.
	  ○ Cleaning and disinfecting all surfaces that may have come into contact with the symptomatic attendee.
	  ○ Requiring hand hygiene and masking of the attendee.
	• The attendee must isolate as soon as possible.

Physical Distancing	Physical distancing means maintaining a distance of at least 2 metres between attendees who are not from the same household at all times. Consider the following controls to encourage physical distancing between attendees:
	• Consider physical controls to support spacing of at least 2 metres or physical barriers to prevent direct contact between attendees. These types of controls reduce the opportunity for transmission. Organizers should consider the following examples and implement appropriate controls for their settings and services:
	  ○ Placing barriers or partitions between attendees.
	  ○ Reducing or removing seats from waiting areas and dining areas.
	  ○ Closing toilets or urinals that are less than 2 metres apart without barriers between them. Washroom capacity must allow for protection of guests. For example, consider or installing barriers between urinals or close off every second urinal.
	  ○ Placing additional hands-free garbage bins with removable linings at all entrances and exits.
	• Where physical controls are not possible or appropriate, the organizer should consider:
	  ○ Reducing the number of attendees at one time.
	  ○ Directing traffic flow within a site. This can be accomplished with signs, ropes, floor decals, etc.
	  ○ Reservations and staggered entry times.
	  ○ Dedicated entry and exit points.
	  ○ Remove all shared items that cannot be easily cleaned.
	  ○ Develop strategies to minimize the handling of objects between multiple attendees and ensure frequent cleaning and disinfecting of these objects.
	• Avoid activities that do not allow physical distancing, such as party games or crowding together for photographs.
	• Contact between attendees, except between members of the same household, should be minimized. Avoid hugging, holding hands, hand shaking

	(e.g., receiving lines) and the sharing of communal items (e.g., pens, guest books). • Chairs and tables should be arranged to ensure two-metres of physical distancing can be maintained. • Attendees should be encouraged to wear non-medical masks when physical distance of two metres cannot be maintained. • Ensure processions have adequate space to move while maintaining physical distancing.

Entertainment & Performances	COVID-19 can be transmitted through saliva or respiratory droplets while singing, or when performing live music, drama or dance in close proximity. As such, these activities should be considered to be higher-risk and either postponed or carefully managed with appropriate physical distancing.
	• Singing and using wind instruments are higher risk activities and not recommended. Consider recorded music or non-wind instruments, like piano or guitar, as an alternative.
	• Hand-held microphones should not be shared. This includes between emcees and those proposing toasts or giving speeches. Podium or stand microphones can be shared, but should not be touched by speakers.
	• Singing by attendees is discouraged. Consider soloist music as an alternative to musical groups or bands.
	• Performances that include singing –soloists or in small groups –should take the following precautions:
	  ○ Keep singers completely separate from the audience and each other by livestreaming individuals singing separately.
	  ○ Limit the number of people singing in the same place to the fewest possible
	  ○ Have people sing facing away from others or otherwise creating separation using an acrylic barrier such as Plexiglas.
	  ○ Use pre-prepared audio or video recordings.
	  ○ Have singers wear face masks while singing.
	• Dancing should maintain physical distancing between attendees from different households.
	  ○ Use chalk lines on sidewalks, spray paint on grass, and tape on flooring to mark spaces for attendees.
	  ○ Consider types of dancing, such as lines dances, which allow people to remain far apart.
	  ○ If attendees are unable to maintain physical distancing while dancing, non-medical face masks should be worn. Guidance for wearing masks is available.
	• Games and other interactive activities should only occur if there are no shared items required. Consider games and activities where participants can maintain physical distance as much as possible.

GUIDANCE FOR OUTDOOR EVENTS

Hand Hygiene & Respiratory Etiquette	Organizers should promote and facilitate frequent and proper hand hygiene all attendees. Organizers should consider the following:
	• Enabling and instructing attendees to wash their hands often with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer (greater than 60% alcohol content).
	  ○ Ensure there are stations available to maintain hand hygiene.
	  ○ It is strongly encouraged that organizers provide a means to sanitize hands at points of entry and locations throughout the site where attendees are known to handle objects.
	  ○ Hand washing with soap and water is required if the attendee has visibly dirty hands.
	  ○ The AHS Hand hygiene education webpage has more information, posters and videos about hand hygiene.
	• Organizers should make every effort to encourage respiratory etiquette (e.g., coughing or sneezing into a bent elbow, promptly disposing of used tissues in a lined garbage bin) is followed.
	• The use of highly visible posters that remind attendees to practice respiratory etiquette and hand hygiene is strongly encouraged (e.g., entrances, washrooms and staff rooms).
	  ○ Posters are available here.
	• Keep washrooms clean and well-stocked with soap and paper towels.
	• If portable restrooms are used, they should include hand sanitizer containing at least 60% alcohol or hand washing stations with soap, paper towel and foot-activated devices adjacent to the units.

Food	• Commercial food operators must comply with any applicable guidance on https://www.alberta.ca/biz-connect.aspx. • Food and beverages should not be served potluck or family-style. • Attendees may bring their own food and beverages. Food and beverages should not be shared between households. • If self-serve, food and beverages should be individually packaged and handled only by the individual who is consuming it. • If food must be handed out, designate an individual to hand out the food. The person handing out food should follow good hand hygiene practices. • Do not preset tables with plates, napkins, glasses, utensils and cutlery. • Use disposable napkins, plates, glasses, utensils and cutlery, if possible.
Cleaning & Disinfecting	Organizers should: • Develop and implement procedures for increasing the frequency of cleaning and disinfecting of high traffic areas, common areas, and public washrooms. • Frequently clean and disinfect high-touch/shared surfaces, such as: ○ Doorknobs, light switches, toilet handles, faucets and taps, elevator buttons, railings.

GUIDANCE FOR OUTDOOR EVENTS

	○ Phones, computers, remote controls, keyboards, desktops, conference room equipment, pin pads, cash registers, surface counters, customer service counters, menus. ○ Equipment handles, hand tools, machinery control panels, seat belt buckles, joysticks, steering wheels and controls on powered mobile equipment. • Limit hours of operations to enable frequent cleaning. • Ensure disposable towels and spray cleaners, or disposable wipes, are available to workers, volunteers and (as necessary) attendees to regularly clean commonly used surfaces. For organizers that do not already have industry specific cleaning and disinfecting standards, the following protocols should be used: • Cleaning refers to the removal of visible soil. Cleaning does not kill germs but is highly effective at removing them from a surface. Disinfecting refers to using a chemical to kill germs on a surface. Disinfecting is only effective after surfaces have been cleaned. ○ Use a "wipe-twice" method to clean and disinfect. Wipe surfaces with a cleaning agent to clean off soil and wipe again with a disinfectant. ○ Items that can be laundered should be machine washed with soap or detergent, using the warmest appropriate water setting and dry items completely — both steps help to kill the virus. • Regular household cleaning and disinfecting products are effective against COVID-19 when used according to the directions on the label. ○ Preferably, use a product labeled as a disinfectant that has a Drug Identification Number (DIN)/ is Health Canada approved. ▪ Health Canada has approved several hard-surface disinfectants and hand sanitizers for use against COVID-19. Use these lists to look up the DIN number (for hard-surface disinfectants) or NPN number (for hand sanitizer) of the product you are using or to find an approved product. ▪ Make sure to follow instructions on the product label to disinfect effectively. ▪ Alternatively, use a bleach-water solution with 20 ml (4 teaspoons) of unscented, household bleach to 1000 ml (4 cups) water. Ensure the surface remains wet with the bleach water solution for 1 minute.
Gifts	• Gifts should be placed in a designated area. Gifts that cannot be cleaned and disinfected should be left untouched for 24 hours. ○ When handling gifts, follow hand hygiene practices. • Gift bags and/or wedding favours should not be placed on tables where guests are seated as may lead to unnecessary handling. ○ Keep gift bags/wedding favours near the exit and encourage the guests to take them when they leave.

COVID-19 INFORMATION

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

Overview

Under current Chief Medical Officer of Health Orders, businesses and entities are required to:

- implement practices to minimize the risk of transmission of infection among attendees;
- provide procedures for rapid response if an attendee develops symptoms of illness;
- ensure that attendees maintain high levels of sanitation and personal hygiene;
- comply, to the extent possible, with the COVID-19 General Relaunch Guidance this guidance, and any other applicable Alberta Health guidance found at Alberta.ca/BizConnect.

This document has been developed to support sport, physical activity and recreation organizations and facilities in reducing the risk of transmission of COVID-19 among attendees (including participants, staff, volunteers, participants and the general public). The guidance outlines public health and infection prevention and control measures specific to (a) sport, physical activity and recreation (indoor and outdoor) and (b) the operation of indoor facilities.

COVID-19 droplet transmission is much more likely when individuals are in close contact. Further, the likelihood of transmission between individuals participating in sport, physical activity and recreation in an indoor setting is significantly higher. While transmission is less likely in an outdoor setting, where air flow is greater and there is more space for individuals to keep physically distanced, transmission can occur if public health guidance is not followed.

COVID-19 can also be transmitted if someone touches a contaminated surface and then touches their face without washing their hands. Many activities involve shared equipment among participants, coaches/staff, instructors, officials or volunteers (for example, shared baseballs, basketballs, volleyballs). The virus does not enter the body through skin; it enters through the eyes, nose or mouth when an individual touches their face. This is why regular hand hygiene and cleaning of high-touch surfaces are so important.

In addition to following the Government of Alberta's guidance, those participating in organized activities sanctioned by, or affiliated with, a provincial or national organization should ensure they are also complying with their governing body's guidelines, assuming they meet or exceed provincial requirements. It is recommended that every organization develop a publicly available written plan. A template can be found in the appendices of the General Relaunch Guidance. The Government of Alberta will not be approving written plans.

This document and the guidance within it is subject to change and will be updated as needed. Current information related to COVID-19 can be found at Alberta.ca/covid19.

 | Published: June 12, 2020

COVID-19 INFORMATION

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

1.0 Facility Considerations

General	• This guidance should be used in conjunction with any additional applicable facility-specific guidance on the Alberta Biz Connect website.
	• Wherever possible, activities should be re-located to outdoor settings.
	• Facility ventilation systems should be both operational and appropriate for the activities practiced within.
	  ○ Facility owners may wish to consult with an expert in Heating, Ventilation and Air Conditioning (HVAC) for assistance.
	• Support healthy indoor air quality by:
	  ○ Discouraging use of scents to prevent sneezing and coughing.
	  ○ Maintaining appropriate humidity levels.
	  ○ Limiting the casual use of overhead ceiling fans or portable pedestal fans as much as possible. If fans are used, minimize air flow that directs current from one person directly toward another.
	  ○ Air filters used in ventilation systems should consider MER-14 or High Efficiency Particulate Air (HEPA) rated filters.
	  ○ Discard air filters carefully to prevent the discharge of viral particles.
	• Provide natural ventilation by opening windows and doors wherever possible to increase air flow.
	• Designate a responsible person to oversee activities to ensure public health guidelines are followed.
	• Consideration should be given to how to appropriately include or accommodate vulnerable persons such as seniors, those with disabilities and persons with compromised immune systems.
	  ○ Examples include reducing attendance, offering virtual methods of engagement and dedicating certain rooms/times for those at greater risk.
	  ○ Instructors/responsible persons may not know who is an at-risk person, so consideration may be given to beginning high-intensity group physical activities with a reminder that there may be increased risk of transmission in these settings, and spacing guidance should be carefully followed.

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

	• Remove unnecessary communal items such as candy, magazines and complimentary phone chargers. Where disposable water cups are provided, place a garbage receptacle close by for any used cups. • Indoor child play centres remain closed at this time.

Staff and Volunteers	• Assign equipment and supplies to individual staff members and avoid any unnecessary sharing.
	• Staff who are exhibiting symptoms of COVID-19, who have returned from international travel in the past 14 days, or who have been in close contact with a case of COVID-19 in the last 14 days must stay home.
	• It is recommended that all staff be knowledgeable with respect to how COVID-19 is transmitted (i.e., droplet and contact transmission).
	• It is suggested that facilities designate a responsible person to ensure public health guidelines are followed (e.g., watching for adherence to physical distancing).
	  ○ The responsible person should not be someone engaged in other critical duties (e.g., referee, lifeguard).
	• Encourage hand hygiene among staff.
	• Staff should wear masks when they are not separated by a physical barrier or 2 metre distance from participants. Guidance is available here.
	  ○ Other personal protective equipment may be appropriate depending on the task being performed (e.g., First Aid or resuscitation).
	• When facility staff are transferring a participant with a disability in and out of equipment, or assisting caregivers with an activity, both the staff member and participant should wear masks whenever a 2 meter distance cannot be maintained.

Points of Entry and Controlling Access	• Physical barriers are recommended to separate front-desk attendants and patrons. • Provide hand sanitizer (60% alcohol or higher) at entry and exit points, and encourage patrons to also bring their own. • Limit physical contact by using online payment and registration or hands-free check in. If wrist-bands are required, the operator should use self-applied bracelets and advise patrons to remove them once they arrive home.

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GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

	• To promote distancing, facilities should consider reducing capacity in each room, venue, court, pool or ice surface in the facility. • Consider using a booking system that sets out specified activity durations (e.g., 1 hour workout periods, 90-minute ice times). • Request that participants arrive no more than 5-10 minutes before their appointment or game. Coordinate appointment or game times to avoid crowding and reduce wait times. • Encourage patrons to limit their time spent in the facility and to maintain physical distancing when returning to vehicles or homes.

Facility Screening	• Consider implementing active screening of attendees (where applicable) and staff for symptoms of fever, sore throat, cough, runny nose or difficulty breathing.
	  ○ Operators may choose to use the Alberta Health Daily Checklist.
	  ○ The Alberta Health Services COVID-19 Self-Assessment tool can be used by attendees
	• Any participant that is exhibiting any symptoms cannot enter the facility or participate.

Sanitation, Cleaning and Disinfecting	• In addition to routine facility cleaning protocols, increase frequency of sanitation of commonly touched surfaces and shared equipment (such as water fountain handles, doorknobs, handrails, light switches, countertops, tables, equipment handles and consoles).
	  ○ A written cleaning and disinfecting schedule is recommended. Encourage staff to document the time a specific area is cleaned.
	• Increase the frequency of cleaning of gymnasium floors to reduce the risk of transmission from shared objects (e.g., balls) and those who use wheelchairs.
	• Provide hand sanitizer throughout the facility and ensure that hand washing sinks are fully stocked with soap and paper towels
	• Follow the cleaning and disinfecting guidance in the General Relaunch Guidance.
	  ○ Follow the disinfectant label instructions for use.
	  ○ Consult the manufacturer's instructions before applying disinfectant to any potentially sensitive equipment in the facility (i.e. touch pads, electronics).
	• Ensure that used cleaning supplies are properly disposed of in a lined waste bin that is emptied at least daily.

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

Locker Rooms and Change Rooms	• Facilities should discourage the use of locker rooms and change rooms whenever possible. ○ Encourage participants to come dressed for their activity. • Set capacity limits on how many people can use locker rooms at the same time. • Adjust lockers to enable physical distancing. • Ensure that surfaces, sinks and toilets in are cleaned and disinfected regularly. • Remove self-serve and common-use items such as hair dryers, cotton swabs and disposable razors.

Physical Distancing	• Alter booking times of facility amenities (e.g., courts, pools, auxiliary rooms) to create a buffer between sessions.
	• Participants and spectators are expected to maintain a distance of 2 metres in lobbies, change rooms, multi-purpose rooms, free-weight areas and while off the field of play (players' bench, bleachers, etc.).
	  ○ For high intensity physical activity (e.g., rows of treadmills and elliptical machines), consider physical barriers or at least three metres distancing between equipment.
	  ○ Distancing exceptions can be made for those who are from the same household.
	• Wherever possible, promote physical distancing by:
	  ○ promoting one-way traffic flow to avoid individuals from inadvertently interacting;
	  ○ placing stickers or signage on the wall/floor at 2 metre distances;
	  ○ spacing seats, or assigning seating, at 2 metre distances;
	  ○ limiting classes and group fitness to cohort groups only (e.g., assigned class times).
	• Facilities should develop procedures that allow for uncongested drop off and pick up of participants. (e.g., drive-thru lanes for pick up and drop off of sport participants, dedicated entrances and exits for incoming and outgoing sport teams)
	• Common area chairs and tables should be stacked, roped off or removed from the area to promote distancing.

Spectators	• Spectators (excluding parents and guardians where necessary for player support) should be kept out of participant spaces (e.g., fields of play, courts, ice surfaces). • Physical distancing of minimum 2 metres should be maintained by spectators/attendee at all times, unless from the same households or cohort family.

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

	• Up to a maximum of 100 seated spectators are allowed, provided a distance of 2 metres between attendees from different households/cohort families is maintained. • It is strongly recommended that all spectators wear masks, especially in an indoor setting. Cheering and yelling is strongly discouraged at this time as it presents a high risk of spreading droplets.

Encouraging Participant Hygiene	• Encourage participants to bring their own equipment to the facility. Wherever possible, limit the use of shared equipment unless participants engaged in the same activity are from the same household.
	  ○ Participant-owned equipment, including sport gloves, should be visibly clean.
	  ○ Equipment handled by hand or head (e.g., tennis balls, basketballs, soccer balls) during play should be frequently cleaned.
	• Where rental equipment is provided, it should be assigned to one person only and be cleaned and disinfected upon return. Do not use equipment that cannot be disinfected.
	• Participants should not share any personal items (e.g., water bottles, towels).
	• Enable and encourage participants to perform frequent hand hygiene before, during and after the activity.
	  ○ Participants can be encouraged to carry and use their own hand sanitizer.
	• Participants should refrain from touching their eyes, nose, mouth and face while participating or while wearing sporting gloves.
	• Encourage participants to exhibit good respiratory etiquette (i.e., sneezing or coughing into the crook of the elbow, no spitting, no clearing of nasal passages, coughing or sneezing into a tissue).

Masks	• Guidance on how to wear a mask properly can be found here. • Patrons and participants may wear a mask when they are not engaging in intense physical activity.
Communications	• Communicate to all participants (coaches/staff, instructors, officials, participants, and their guardians, volunteers) about the risk of COVID-19 and practices that should be undertaken to mitigate risk. ○ Communication platforms could include online registration forms, rental contracts and automated telephone switchboards.

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

	• Information posters and fact sheets can be downloaded here. Place appropriate signs throughout the facility explaining:
	  ○ Physical distancing expectations
	  ○ Hand hygiene and respiratory etiquette
	  ○ Cleaning and disinfection practices
	• In the event that a participant requires basic first aid, consider having a family member attend to the injured. If not possible, if the first aider is a facility employee they should use appropriate personal protective equipment, including a mask and gloves.

Equipment	• Reconfigure fitness equipment (e.g., weight machines) to promote physical distancing. Consider installing physical barriers between equipment wherever increased distancing is not possible. ○ It is strongly recommended that both physical barriers and at least 3 metres of distance greater distances be placed between equipment used for high intensity activities (e.g., treadmills, stationary bikes) to lessen the likelihood of transmission from higher exertion. • Have processes to ensure enhanced cleaning and disinfection of shared fitness equipment between each use by having readily available supplies and cleaning reminders and instructions located in accessible places. Facility staff should ensure that cleaning occurs between uses.

Rapid Response to Symptomatic Individuals	• Facilities and organizers are required to have a rapid response plan in place to manage symptomatic participants, spectators and staff. A rapid response plan sets out a fast-action plan for operators when an attendee shows symptoms of COVID-19.
	  ○ Details on rapid response can be found in the General Relaunch Guidance.
	• Plans should include:
	  ○ Immediate isolation of the symptomatic participant from others, including arrangement for safe travel home (e.g., no public transit).
	  ○ Consideration of suspension or temporary cancellation of the event.
	  ○ Cleaning and disinfecting of all equipment and surfaces that may have come into contact with the symptomatic participant.
	  ○ Performance of hand hygiene by remaining participants.

Facility Amenities / Food and Beverage	• Venues that offer food or beverage services must adhere to the Guidance for Restaurants, Cafes, Pubs, and Bars.

GUIDANCE FOR SPORT, PHYSICAL ACTIVITY AND RECREATION – STAGE 2

	• Ensure vending machines are cleaned frequently, in particular touch keypads.

2.0 General Considerations for Sport, Physical Activity and Recreation Organizations

Considerations for Modifying Activities	To help plan activities, practices or games, consider the following: • Can the activity be modified to reduce the sharing of equipment touched by hands or sporting gloves? • Can the activity be modified to increase opportunities for physical distancing? • Can the activity be done outdoors instead of indoors? • Can activities, practices and game play be shortened, or performed with fewer participants?

Mini-leagues: Cohorting Participants	• All aspects of organized sport, physical activity and recreation may proceed (programming, training, practice and competition) if physical distancing is possible.
	• If those not participating in physical activity are unable to maintain safe physical distancing, masks should be worn. In sports and activities that generally involve interaction between participants at a distance of less than 2 metres, it is recommended that:
	  ○ The activity occur outdoors, or
	  ○ Modification of the activity or sport occur to keep participants at a safe distance.
	• Where sports and activities cannot be modified to maintain distance, limit the number of contacts between different participants. This is done by playing within set cohorts[1] (e.g., mini-leagues, with a fixed number of participants).
	  ○ Mini-leagues should not exceed 50 people. This number includes those participants, officials, coaches and trainers who cannot maintain 2 metres of distance from others at all times. This number does not include parents and spectators.
	• Cohorts or mini-leagues should remain together during Stage 2 of Relaunch and only play within the same geographical region (e.g., within a county, town or quadrant of a city).
	• It is recommended that mini-leagues be supervised by a responsible person whose role is oversight over maintenance of the group and other public health guidance.

[1] Cohort is defined as a closed, small group of no more than 50 individuals who participate in the same sport or activity, and remain together for the duration of Stage 2

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Public Health Contact Tracing	• Participants, coaches, instructors, officials or volunteers who become symptomatic during an activity are required to be isolated from others and must return home immediately. • To support public health contact tracing efforts in the event that an attendee tests positive, operators should consider collecting the names and contact information of attendees. • Providing information is voluntary for attendees. An organization must obtain an individual's consent and notify them about the purpose and legal authority for the collection. • Information about attendees will only be requested by Alberta Health Services if a potential exposure occurs onsite. • For businesses/workplaces, this includes staff, workers and volunteers on shift. Where feasible to do so, and particularly for personal services and group events, it should also include patrons/customers/the general public. • Records should only be kept for two weeks. An organization must make reasonable security arrangements to protect the personal information. • Any personal information that is collected for COVID-19 contact tracing can only be used for this purpose, unless an individual provides their consent. • For more information, the Office of the Information and Privacy Commissioner has released Pandemic FAQ: Customer Lists about collecting personal information from customers during the COVID-19 pandemic. • For questions about your obligations under PIPA, please contact the FOIP-PIPA Help Desk by phone at 780-427-5848 or by email at sa.accessandprivacy@gov.ab.ca. • Organizations may encourage participants to download the ABTraceTogether contact-tracing app to assist public health officials with contact tracing in the event an outbreak should occur.

Masks	• Participants can wear masks when they are not engaging in intense physical activity.
	• Masks should NOT be worn when conducting intense physical activities.
	  ○ Masks and face shields cannot be assured to stay in place during the course of intense activity.
	  ○ There is some evidence to suggest that wearing a mask during high intensity activities could have negative health effects.
	  ○ Mask use during swimming can increase the likelihood of choking or drowning.

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Participants, Coaches, Instructors, Staff, Volunteers, Officials, Aides	• Participants should proactively and regularly monitor for symptoms. Symptomatic individuals are prohibited from participating.
	• Hand hygiene should occur before and after each activity.
	  ○ Hands should be cleaned before and after using sporting gloves.
	  ○ Gloves should be cleaned after each use.
	• To the extent possible, participants should refrain from touching their eyes, nose, mouth and face during activity.
	• Practice respiratory etiquette. Participants should refrain from spitting and clearing their nasal passages during activities.
	• Limit group celebrations and other customs during activities (e.g., handshakes, high fives, fist bumps, chest bumps) that bring participants with 2 meters or promote contact.
	• Water bottles should be labelled with the name of the owner. Do not share water bottles.
	• To the extent possible, arrive dressed and ready to participate. There will be limited access to locker rooms to prevent gathering.
	• After activities, individuals should minimize time spent in dressing/locker/change rooms and maintain physical distance lobbies and common spaces.
	• Transportation to and from activities should be arranged so that only cohort members, or members from the same household, share rides.

Competition and Mini-League Play	• For those activities where participants are unable to adhere to physical distancing, cohorts of a total of 50 individuals should be formed (mini-league).
	  ○ Mini-leagues should remain together for the duration of Stage 2 of Relaunch.
	  ○ Mini-leagues allow sport teams to return to a safe level of play, and will help to mitigate risk of widespread transmission by limiting the number of athletes that come within close contact.
	• The 50 person maximum includes coaches/staff, instructors, participants from multiple teams, officials, and volunteers who cannot maintain 2 metres of distance from others at all times.
	• Each mini-league can be comprised of multiple teams, to a maximum of 50 people. Within each mini league, game play can resume between teams.
	  ○ Game play between teams must be limited to teams within the same cohort/mini-league.
	  ○ Teams in different mini-leagues should not play each other.
	• At least 2 metres distancing should be maintained between all when off the field of play (e.g., on benches, during intermission).

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	○ The 2 metre physical distancing rule can be relaxed for participants from the same household.
Travel	• For Stage 2 of Relaunch, activities should be restricted to local community opportunities. Participants should not seek sport, physical activity and recreation opportunities in other regions, or out of province. ○ Cross-jurisdictional, or inter-regional, play should not occur at this stage.

3.0 Sport and Activity-Specific Considerations

High intensity Fitness Classes and Studios (Dance, High Intensity Classes)	• There is no scientific evidence establishing a 'safe' distance between participants during indoor high intensity activities. ○ Both operators and participants should proceed with this type of exercise with caution and should take appropriate measures to reduce risk of exposure and transmission. • For high-intensity class (e.g., Zumba®, Spin®/cycle class, hot yoga, boot camp), reduce the overall number of participants in classes to ensure that a minimum distance of 3 meters is maintained in all directions of each participant. ○ Increase physical distance, or install physical barriers, between the instructor and participants. • Allow adequate time to thoroughly clean and disinfect equipment between each class. • Instructors should be assigned and wear microphones to reduce the need for shouting. ○ Participants singing along to the music or shout back at the instructor should be discouraged. • Consider creating cohorts of classmates by assigning specific times for the same participants to partake in classes. • Mitigate the potential for classmates to gather before and after a class within the facility. • Ensure group fitness classrooms are well ventilated (e.g., open windows if possible). • For classes with significant movement (i.e. dance, fighting), it is recommended the program be altered to limit the need to travel within the room. Consider dancing in a designated area or moving the class outdoors.

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	• Dance lessons for couples from the same household or cohort family can proceed with 2 metres of spacing maintained between couples.
Low Intensity Fitness Classes (e.g. Yoga, Pilates)	• Participants should be encouraged to bring their own equipment (e.g. mats, blocks). • If equipment is shared, it should be cleaned and sanitized between users. • Where fitness activities involve participants in close proximity to the floor, the floor should be cleaned thoroughly between each class. • Participants should be arranged to maintain 2 metres distance between each other at all times.
Weight Rooms	• Space weight machines at least 2 metres apart. • Consider greater distances (3 metres) between aerobic fitness equipment where high exertion is common (e.g., treadmills, rowing machines, stationary bikes). • Designate areas for the use of certain equipment (e.g., stretching areas, kettle bell areas) and for movement (e.g., heavy rope, tire flipping zone) to ensure distancing is maintained. • Consider using markers on the floor to define designated areas and manage flow of participants. • If equipment cannot be moved, and positioning will result in participants being within a 2 metre distance, consider blocking off every other piece of equipment or erecting barriers such as acrylic glass between equipment. • Where spotting is necessary for heavy weight lifting, participants may form small cohorts to limit direct contact with others.
Indoor Tracks	• Width of track lanes should be considered for physical distancing. Consider limiting the use of every second lane. • It is suggested that runners travel in the same direction on the track. • Encourage outdoor running wherever possible.
Squash and Racquet Ball Courts	• Where not playing with family members, participants should play within a cohort/mini league. • Encourage participants to bring their own clean equipment when possible. ○ Where equipment is rented, operators should clean and disinfect between uses.

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Gymnastics and Rock Climbing	• Establish appointments and designate climbing times to ensure physical distancing can be maintained. • Climbers and gymnasts should be asked to thoroughly wash their hands before and after using shared equipment (e.g., climbing holds, beams, rings). • Many surfaces in these settings cannot be effectively sanitized. Facilities may consider modifying training to limit the number of surfaces handled by participants. ○ Encourage climbers to clean hands immediately prior to and after use. • Remove any self-serve chalk bowls and require participants to bring their own chalk. • Remove mats and other equipment that is torn or in disrepair as these items cannot be effectively sanitized. • If gear or equipment rental is permitted, ensure it is cleaned and disinfected after being returned. • Enhance the frequency of cleaning of handholds, rings, bars and other frequently handled surfaces. • Consult the Alberta Gymnastics Cleaning Guide for specific instructions on how to clean equipment.
Arena Sport (Figure Skating, Ringette, Hockey)	• Ice use should be limited to organized activities (e.g., figure skating, hockey, ringette). No more than 50 people can be on the ice/boxes at the same time. This includes referees and coaches, but does not include spectators.
Multi-use Gymnasiums, Fieldhouses and Community Centres	• Total number of individuals in a gymnasium setting should not exceed 100. • If different activities are conducted in the gymnasium setting, cohort groups should be kept separate. Physical barriers (e.g., curtains) are recommended if possible. ○ Participants of different activities should not mix with other activity participants. • Organized court sports (e.g., volleyball, basketball, badminton, pickle ball) may occur with cohorts of no more than 50 persons. • Players should follow marked one-way traffic patterns when entering and exiting the gymnasium. • Gymnasium floors should be thoroughly cleaned at an enhanced frequency.

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Martial Arts, Mixed Martial Arts, Wrestling, Boxing	• For any activities with close and sustained contact between participants, cohorts should be used to the greatest extent possible. ○ For this setting, cohorts should be comprised of those from the same weight class or skill level. • Remove any mats or equipment that is torn or in disrepair, as these items cannot be properly cleaned and disinfected.
Personal Training /Coaching/Nutritional Consultations	• These services should continue to be offered virtually, or outdoors, if possible. • In-person sessions should allow for physical distancing or barriers between the client and trainer. If this is not possible, the trainer should consider wearing a mask.
Pool and Aquatic Activities (Swimming, Diving)	• Consult the Guidance for Swimming Pools.

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