IPAC e-learning Program

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Introduction

Due to the COVID-19 pandemic, strict infection prevention and control (IPAC) procedures have been adopted for providers of developmental services and congregate care establishments. The Joint IPAC Hub is a committee within Simcoe County and Muskoka that represents Transfer Payment Agencies (TPA) and Outside Paid Resources (OPR) congregate care operators in the Simcoe Region. Through ongoing discussions, the IPAC Hub understood that IPAC practice, while based on Ministry of Children and Community Service and Public Health regulations, are varied across member organizations.

Background

Previously, congregate care organizations, childcare services providers, and others within this group developed and conducted their own IPAC training programs. Taken together, this led to variations in IPAC practices and processes. As such, the IPAC Hub identified a need for standardized best practices, access to training materials, and an accompanying training toolkit. The IPAC Hub Committee reached out Georgian College for help to develop an IPAC e-Learning program and complementary toolkit.

This project is a collaboration amongst Georgian College, the Ministry of Children and Community Services, the Simcoe County RVH and the South Simcoe/York Region SRHC Hub Champions including Dr. Howard Bloom, Blossom Group (Blooming Acres/Apple Blossom Village); Dr. Claudine Cousins, Empower Simcoe; Dean Johnson, CLH Developmental Support Services; Irene Moore, Christian Horizons – Southlake Hub, South Simcoe/York Region. Christine Vallis-Page; Andrew Walker, CLASS, Southlake Hub, South Simcoe/York Region.

Goals and Objectives

The overall goal of this project is to put forth an IPAC curriculum specific to congregate care settings to enable and prepare current and future employees with the necessary IPAC skills. Additionally, this curriculum assists IPAC Hub partners in planning, training and responding to current and future IPAC needs. Finally, this project provides curriculum for college-level human service programs as supplemental material to train future employees who will support people in congregate care settings.

To undertake this endeavor, the IPAC Hub partnered with Georgian College's Centre for Applied Research and Innovation (CARI). Georgian College assembled a team which consisted of both faculty and students to gather IPAC information including strategies, teaching tools, and procedures from participating stakeholders in Simcoe County including developmental service partners, Royal Victoria Regional Health Centre (RVH), and Simcoe Muskoka District Health Unit (SMDHU). After doing so, the team consolidated and drafted this information into this curriculum and toolkit.

This curriculum and toolkit is designed around the following modules:

Screening Protocols

Cleaning and Disinfecting

Hand Hygiene Policies

IPAC Emergency Response

PPE Related Documents

Isolating-Cohorting and Infection Management

Visiting form and considerations

These modules were designed to be accessed asynchronously and non-chronologically. For example, participants can start with any module, engage with the contents of the module, and decide which module to explore next. Additionally, the design format of these modules are intentionally basic. In doing so, we were mindful of the variety of ways in which users would interact with and personalize this curriculum as well as ensure that this curriculum could be reproducible and fully accessible.

Within each module, participants are encouraged to review the following documents in the following order: Preamble, Learning Outcomes and Curriculum Document. Each module also includes the following sub-folders which participants can explore as they choose: Sample Signage; Sample Agency Instructional Resources; and Sample Policies, Procedures, and Protocols. These "Sample" sub-folders contain relevant documents which were generously shared by IPAC Hub partners. The intention of providing these sample documents is to illustrate how agencies and institutions within the Simcoe Muskoka IPAC Hub have responded to the nuances of IPAC measures within congregate care settings. Additionally, such samples are meant to assist agencies and institutions to design and create their own IPAC-related documentation and training.

Acknowledgements

The faculty and student team from Georgian College would like to acknowledge the following contributions to this project:

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Webinar Narration: Erin Gilchrist, Sanmeet Kaur Arora, Stephen Skinner and Blessing Aladeseye

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Cleaning and Disinfecting Module

Preamble

This module pertains to cleaning and disinfecting processes and protocols in congregate care settings.

This module is organized around the following topics:

What is cleaning & disinfecting?

Why is cleaning & disinfecting required?

Which surfaces require cleaning &

disinfecting? When is cleaning &

disinfecting required?

How are surfaces properly cleaned and disinfected?

This module consists of the following documents and sub-folders:

Cleaning & Disinfecting Learning

Outcomes Cleaning & Disinfecting

Curriculum

Sample Policies for

Implementation Sample

Signage for Public Education

Samples Agency Instructional

Resources

Learning Outcomes for Cleaning and Disinfecting

After completing this module, participants should be able to:

Define cleaning, disinfecting, and sanitizing

Describe the typical pathway of infection

Identify how cleaning & disinfecting prevent cross-contamination

Describe when and how cleaning & disinfecting personal protective equipment (PPE) should be used and disposed

Describe which surfaces need to be cleaned, when, and how often

Identify the required steps to effectively clean & disinfect a surface

Identify the importance of documenting the cleaning and disinfecting of surfaces

Identify how to obtain additional information and instructions related to cleaning and disinfecting processes, protocols and procedures

Explain how cleaning and sanitizing prevent cross-contamination

Cleaning and Disinfecting Curriculum

This module is organized around the following topics:

What is cleaning & disinfecting?

Why is cleaning & disinfecting required?

Which surfaces require cleaning & disinfecting?

When is cleaning & disinfecting required?

How are surfaces properly cleaned and disinfected?

What is Cleaning & Disinfecting?

According to the Centre for Disease Control (CDC), there are important differences between cleaning and disinfecting:

Cleaning removes germs, dirt, and impurities from surfaces or objects. Cleaning works by using soap (or detergent) and water to physically remove germs dirt, and impurities from surfaces. This process does not necessarily kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.

Disinfecting kills germs on surfaces or objects. Disinfecting works by using chemicals to kill germs on surfaces or objects. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after disinfecting, it can further lower the risk of spreading infection.

Sanitizing lowers the number of germs on surfaces or objects to a safe level, as judged by public health standards or requirements. This process **works by either cleaning or disinfecting** surfaces or objects to lower the risk of spreading infection.

Source: https://www.cdc.gov/flu/school/cleaning.htm

Why is Cleaning & Disinfecting Required?

According to the Provincial Infectious Diseases Advisory Committee (PIDAC), each of the following steps are required for environmental contamination to result in infection:

1. The environment becomes contaminated with microorganisms.
2. The microorganisms survive for a sufficient duration to allow transmission.
3. Clients/patients/residents
a) Acquire the microorganism through direct contact with the environment.
b) Hands or gloves of health care providers or equipment becomes contaminated through direct contact with the environment and transmit the microorganism to another client/patient/resident due to lapses in hand hygiene and/or disinfection of shared equipment.
4. Acquisition of a microorganism that results in infection.

However, effective environmental cleaning will interrupt direct client/patient/ resident to surface to client/patient/resident transmission of microorganisms, and minimize (along with effective hand hygiene) surface to health care provider to client/patient/resident transmission.

Both the steps and the demonstration of how effective environmental cleaning are demonstrated in figure 1 below:

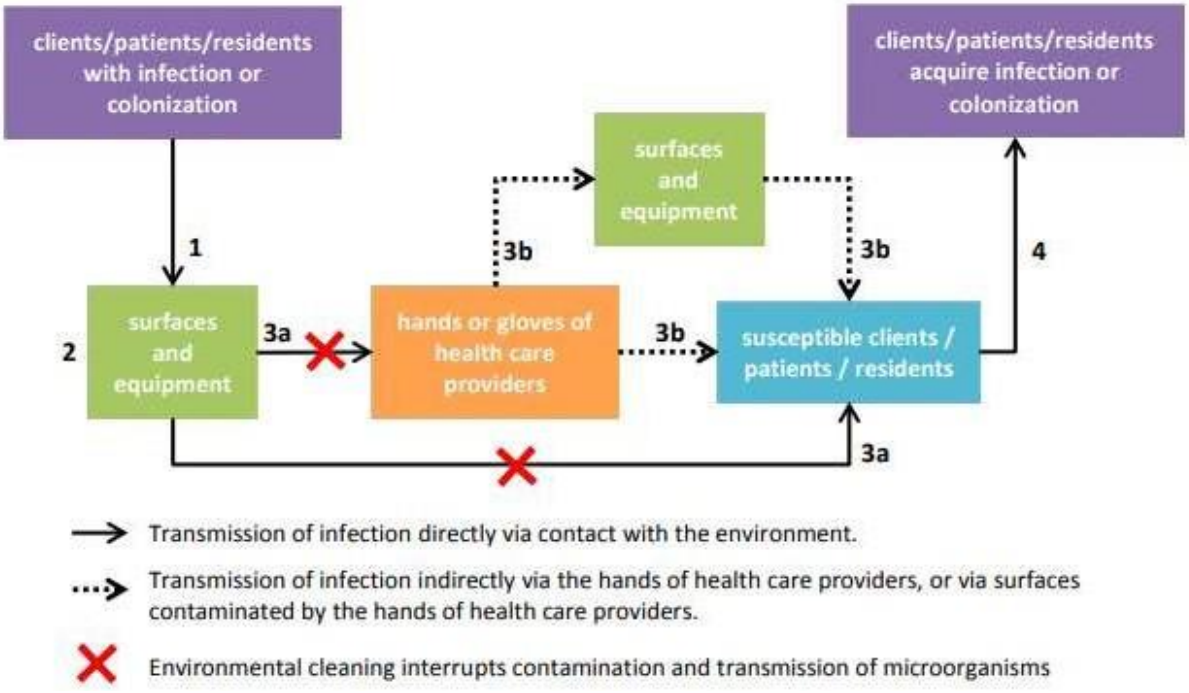


Figure 1

Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings. 3rded. Toronto, ON: Queen's Printer for Ontario; 2018.

Which Surfaces Require Cleaning & Disinfecting?

As noted by the North Bay Parry Sound District Health Unit (2020), "a contaminated environment can play a role in the transmission of infection. In the group home setting, the role of environmental cleaning is important because it reduces the number and amount of infectious agents that may be present and may also eliminate routes of transfer of microorganisms from one person/object to another, thereby reducing the risk of infection".

It is therefore useful to distinguish surfaces into two distinct categories: ***high-touch and low-touch.***

High-touch surfaces in the immediate vicinity of a resident may be a reservoir for pathogens. The hands of residents and staff transmit these pathogens directly or indirectly.

Low-touch surfaces are those that have minimal contact with hands.

Source: https://www.myhealthunit.ca/en/health-professionals-partners/resources/Group-home-and-shelter/2020-FINAL-IPAC-Resource-for-Group-Homes-Repaired.pdf

High-touch surfaces include:

Doorknobs/frames/handles/other frequently touched areas on the door

Locker doors/cubby holes/storage bins.

Desks/tables/chairs/counter tops

Hand railings

Light switches

Water fountains

Elevator buttons

Shared equipment (such as crafts, sports equipment and musical instruments after each use, computer keyboards and mice, etc.)

Telephones/faxes/photocopiers/intercoms

Recreation areas and toy storage areas

Floors (especially where residents may sit on the floor)

Source: https://www.ottawapublichealth.ca/en/professionals-and-partners/cleaning-and-disinfection-checklist.aspx

Kitchen/staff room:

Food preparation areas and equipment

Counter tops

Fridge handles

Microwaves

Coffee pots/kettles

Tables/chairs

Washrooms:

Stall door edges and locks

Coat hooks

Sanitary napkin dispensers

Paper towel dispensers

Soap dispensers

Taps/faucets

When is Cleaning & Disinfecting Required?

It is recommended that **high-touched** surfaces be cleaned and disinfected at least daily and more frequently when there is an increased risk of contamination (e.g. during an outbreak). **Low-touch** surfaces can be cleaned less frequently (e.g. weekly, monthly) but cleaned sooner if visibly soiled.

Of course, the frequency of cleaning and disinfecting is dependent on the quantity of germ exposure to a given surface. For example, we would expect door handles to require more frequent cleaning/disinfecting than door frames. If there is a known pathogen/virus present, cleaning and disinfection of surfaces and items is required more often.

Source: https://www.myhealthunit.ca/en/health-professionals-partners/resources/Group-home-and-shelter/2020-FINAL-IPAC-Resource-for-Group-Homes-Repaired.pdf

How are Surfaces Properly Cleaned and Disinfected?

A process must be in place regarding cleaning of the environment that includes:

Choosing finishes, furnishings and equipment that are cleanable

Ensuring compatibility of the environment's cleaning and disinfecting products with the items and surfaces to be cleaned

Identifying when items can no longer be cleaned due to damage

Following the manufacturers' recommendations for all cleaning and disinfecting products

Source: https://www.myhealthunit.ca/en/health-professionals-partners/resources/Group-home-and-shelter/2020-FINAL-IPAC-Resource-for-Group-Homes-Repaired.pdf)

USE OF PPE FOR ENVIRONMENTAL CLEANING

The use of personal protective equipment (PPE) is often a requirement for cleaning and disinfecting. Adequate supplies of PPE should be readily available and donned when directed, or when cleaning due to additional precautions.

PPE is encouraged in the following situations:

Gloves must be worn when there is a risk of coming into contact with blood, body fluids, excretions, or secretions, or an item or surface that may be contaminated with them.

Gowns must be worn if contamination of clothing is anticipated. Gowns must be changed after use and should never be worn or reused between tasks or areas.

Masks and eye protection are worn whenever there may be risk of contamination coming into contact with mucous membranes of the eyes, nose, and mouth.

In the event of a pandemic or infectious disease outbreak, staff may be required to wear certain PPE at all times while in the home. In this instance, PPE recommendations remain unchanged, and PPE items that become contaminated should be changed and replaced after cleaning has been completed.

GLOVE USE

Select the most appropriate gloves to be worn based on the type of activity being performed. Gloves should be selected based on a risk analysis of the type of setting, the task being performed, the likelihood of coming into contact with blood or body fluids, and the length of the activity and/or amount of stress placed on the gloves. Gloves must be worn as recommended on a product's Safety Data Sheet.

General guidance for glove use during cleaning:

Disposable gloves may be used for routine dailycleaning and disinfection of resident areas, common areas, and/or bathrooms.

Durable polymer gloves compatible with the SDS of products used should be worn when performing wet work of long duration (e.g., deep cleaning of kitchens or bathrooms), for cleaning where durability of gloves is required, for deep cleaning of bedrooms between resident occupancy, and for contact with chemicals that are identified as requiring durable gloves for handling.

Puncture-resistant gloves should be worn if the task being performed has a high risk for percutaneous injuries such as needle sticks or cuts.

Important points to remember:

Use single use cloths or disposable paper towels to clean sinks and toilets/urinals

Ensure an adequate supply of paper towels and soap

Do not top up partially empty dispensers; once empty, containers should be cleaned, disinfected, dried, and then refilled

Soap/detergent must be rinsed off prior to disinfection

Follow instructions. It might be tempting to mix cleaning products to make sure your facility is germ-free -- but don't. Mixing some cleaners and disinfectants (like chlorine bleach and ammonia) can be harmful, even deadly. Others can irritate your eyes, nose,

Hand Hygiene Module

Preamble

This module pertains to processes and protocols for hand hygiene in congregate care settings.

This module is organized around the following topics:

What is hand hygiene?

Why is hand hygiene required?

When is hand hygiene required?

How is hand hygiene completed?

What are situation factors associated with hand hygiene (soap and water, or hand sanitizer)

This module consists of the following documents and sub-folders:

Hand hygiene Learning Outcomes

Hand hygiene Curriculum

Sample Policies for Implementation

Sample Signage for Public Education

Learning Outcomes for Hand Hygiene

After completing this module, participants should be able to:

Define hand washing

Identify the appropriate methods of hand washing for a given situation

Describe when and how to practice hand washing

Identify the importance of hand washing as it relates to the reduction in infection prevention and control

Resource additional information and instructions related to hand washing protocols and procedures

Hand Hygiene Curriculum

This module is organized around the following topics:

What is hand hygiene?

Why is hand hygiene required?

When is hand hygiene required?

How is hand hygiene completed?

What are the implications of soap and water versus hand sanitizer?

Who should be practicing hand hygiene?

What is Hand Hygiene?

Public Health Ontario states that hand hygiene relates to the removal of visible soil and the removal or killing of transient microorganisms from the hands. Hand hygiene may be accomplished using an alcohol-based hand rub, or with soap and running water.

Hand hygiene is an effective strategy to prevent infections and limit the transmission of microorganisms, including antibiotic-resistant organisms. It is a required practice for all health care providers, is recommended in all national and international infection control guidelines and is a basic expectation of patients and their families. Hand hygiene is one of the five key initiatives set out by the World Alliance for Patient Safety's Global Patient Safety Challenge.

Source: PIDAC established protocol for best practice in hand washing- https://www.publichealthontario.ca/-/media/Documents/B/2014/bp-hand-hygiene.pdf?sc_lang=en

Why is Hand Hygiene required?

The most common vehicle for the transmission of microorganisms from and to clients and equipment in the environment is from hands. During the delivery of care, the support provider's hands continuously touch surfaces and substances including inanimate objects, client/patient/residents intact or non-intact skin, mucous membranes, food, waste, body fluids and the health care provider's own body.

The total number of hand exposures in a health care facility might reach as many as several tens of thousands per day. With each hand-to surface exposure, a bidirectional exchange of microorganisms between hands and the touched object occurs and the transient hand-carried flora is thus continuously changing. As such, microorganisms can spread throughout a health care environment within a few hours.

Completion of quality and quantity hand hygiene practices is the single most important practice for preventing the transmission of microorganisms in health care and directly contributes to patient and staff safety.

When is Hand Hygiene required?

Public Health Ontario states that "a hand hygiene indication" points to when hand hygiene is required in each situation. Examples of hand hygiene indications are:

before initial contact with a client/patient/resident or items in their environment; this should be done on entry to the room or bed space, even if the client/patient/resident has not been touched

before putting on gloves when performing an invasive/aseptic procedure

before preparing, handling or serving food or medications to a client/patient/resident

after care involving contact with blood, body fluids, secretions and excretions of a client/patient/resident, even if gloves are worn

immediately after removing gloves and before moving to another activity

when moving from a contaminated body site to a clean body site during health care

after contact with a client/patient/resident, or items in their immediate surroundings, even if the client/patient/resident has not been touched

whenever in doubt

Public Health Ontario has simplified these moments to the four crucial moments of hand hygiene:

The 4 Moments for Hand Hygiene in All Health Care Settings:

1. **BEFORE initial patient/patient environment contact**
2. **BEFORE aseptic procedure**
3. **AFTER body fluid exposure risk**
4. **AFTER patient/patient environment contact**

Best Practices for Hand Hygiene in All Health Care Settings | 12

How is Hand Hygiene completed?

Hand hygiene practice depends on the method. The two most common methods are alcohol-based hand rubs and hand washing with soap and water. Hand washing with soup and water is best practice.

How to Hand Rub

How to Hand Wash

How do I use alcohol-based hand rubs?

Alcohol-based hand rubs should only be used if no visible dirt is present on the hands:

Remove hand and arm jewelry

Apply enough alcohol-based hand rub to make about the size of a quarter onto your hands, enough when you rub your hands together to cover all areas of your hands, including under your nails (1-2 pumps)

Use a rubbing motion to evenly distribute the alcohol-based hand rub over all surfaces of the hands, particularly between fingers, fingertips, back of hands and base of thumbs

Rub hands until your hands feel dry (minimum 15-30 seconds)

How do I use soap and water?

Good hand hygiene technique is easy to learn. Follow these five simple steps to keeping your hands clean:

Remove all your hand and arm jewelry and wet your hands with warm (not hot) running water

Add soap, and then rub your hands together, making a soapy lather. Do this for at least 15 seconds, being careful not to wash the lather away. Wash the front and back of your hands, as well as between your fingers and under your nails

Rinse your hands well under warm running water, using a rubbing motion.

Wipe and dry hands gently with a paper towel

Turn off the tap using a paper towel so that you do not contaminate your hands

What are some mistakes regarding hand hygiene?

DON'T leave hand jewelry on when performing hand hygiene. Jewelry is very hard to clean and hides bacteria and viruses from the mechanical action of the washing/rubbing.

DON'T use artificial nails, nail enhancements or long (>3-4mm) nails, as they trap bacteria and are difficult to keep clean.

Be aware that chipped nail polish increases the risk of bacteria which may become trapped along the edges

DON'T use a single cloth to wash or dry a group of patient's/resident's/children's hands

DON'T use a standing basin of water to rinse hands

DON'T use a common hand towel

DON'T use sponges or non-disposable cleaning cloths. Remember that germs thrive on moist surfaces

What are the Implications of Soap and Water Versus Hand Sanitizer?
When should soap and water be used?

The mechanical action of washing, rinsing and drying removes transient bacteria present on the hands. Hand washing with soap and running water must be performed whenever hands **are visibly soiled.**

Any type of plain soap may be used. However, bar soaps are not acceptable in health care settings except for single patient/resident personal use. If used, bar soap should be kept in a self-draining holder that is cleaned thoroughly before new bars are distributed.

When should alcohol-based hand rubs be used?

Alcohol-based hand rubs/gels/rinses are the preferred method for decontaminating hands, provided they contain more than 70% alcohol. They are widely used in healthcare settings, or in situations where running water is not available. Using alcohol-based hand rub is better than washing hands (even with an antibacterial soap) when hands are not visibly soiled.

Will frequent hand hygiene dry my skin?

Intact skin is the first line of defense against microorganisms. Hence, it is important to maintain good skin care. To prevent chafing, wet your hands before applying soap and use a mild lotion soap with warm water; pat rather than rub hands dry; and apply lotion liberally and frequently. Skin lotions should be chosen that will not interfere with glove integrity.

Most alcohol-based hand rubs contain emollients to reduce the incidence of skin irritation. Frequent use of alcohol-based hand rub lessens the incidence of skin breakdown as it does not subject hands to the friction and abrasion involved in hand washing and drying hands.

Source: https://ipac-canada.org/hand-hygiene

Who should be practicing hand hygiene?

To prevent and control the spread of infections, hand hygiene should be practiced by all practitioners, clients and visitors. All staff, volunteers and family members are to clean hands according to the 4 Moments for Hand Hygiene (see above).

HAND HYGIENE FOR THE CLIENT/PATIENT/RESIDENT: Personal hand hygiene for clients/patients/residents is important. Clients/patients/residents should be encouraged or assisted to perform hand hygiene.

Source: https://www.publichealthontario.ca/-/media/Documents/B/2014/bp-hand-hygiene.pdf?sc_lang=en

For additional resources, visit the following link:

Hand Hygiene E-learning Tool -Infection Prevention and Control Canada and Discovery Campus offer an online hand hygiene education module for healthcare workers and volunteers

IPAC Emergency Response Proposals Module

Preamble

This module pertains to Infection Prevention and Control (IPAC) emergency response and pandemic planning in congregate care settings.

This module is organized around the following topics:

What is IPAC emergency response planning?

Why is IPAC emergency response planning important?

Who is responsible for IPAC emergency response planning?

When should IPAC emergency response plans be implemented?

This module consists of the following documents and sub-folders:

IPAC Emergency Response Plans Learning

Outcomes IPAC Emergency Response Plans

Curriculum

Sample Policies for Implementation

Sample Signage for Public Education

Learning Outcomes for IPAC Emergency Response Plans

After completing this module, participants should be able to:

Explain why IPAC emergency response planning is necessary

Describe who is responsible for IPAC emergency response planning

Identify the three common types of outbreaks

Describe the common characteristics of each type of outbreak Identify

who is responsible for IPAC emergency response planning

Identify the common types of guidelines and protocols of IPAC emergency response planning in congregate care settings

Explain when an IPAC emergency response plan should be implemented for each type of outbreak

IPAC Emergency Response Plans Curriculum

This module is organized around the following topics:

What is IPAC emergency response planning?

Why is IPAC emergency response planning important?

Who is responsible for IPAC emergency response planning?

When should IPAC emergency response plans be implemented?

What is IPAC Emergency Response Planning?

Specific to infection prevention and control, emergency response planning is the strategic management of outbreaks.

Within healthcare and congregate care environments, infectious disease outbreaks are commonly spread through contact, droplet, or airborne transmission. Typically, outbreaks can be categorized as enteric, respiratory and/or COVID -19. Each type of outbreak requires a particular and site-specific IPAC emergency response plan.

Enteric Outbreaks

Enteric outbreaks, also known as gastroenteritis outbreaks, are infectious disease outbreaks that can occur in healthcare settings throughout the year. Enteric illnesses are typically caused by bacteria, viruses, or parasites, and are transmitted through the consumption of contaminated food or drink, or through contact with contaminated persons, objects, or surfaces. Common symptoms of enteric infection include nausea, vomiting, diarrhea, abdominal cramps, fever, chills, and loss of appetite. Symptoms may appear as early as 30 minutes or as late as 10 days following infection.

Respiratory Outbreaks

Respiratory outbreaks occur in healthcare facilities and congregate living settings when a resident or staff member develops symptoms of an acute respiratory illness (ARI). These infections may occur at any time of the year but are more common in colder winter months (i.e., "flu season"). A wide range of ARIs exist which can cause infections of either the upper or lower respiratory tract, but typically display similar symptoms of a new or worsening cough and shortness of breath or difficulty breathing. Many cases of ARI also develop a fever. ARIs are typically caused by viruses or bacteria, which enter the

body through the mucous membranes of the nose, mouth, or eyes and settle in the respiratory tract. Respiratory infections spread through the home through droplets that are spread through sneezing, coughing, and contact with the mucous membranes of an infected individual. Depending on the size of the infectious droplets and whether they remain in the air for a prolonged period of time or settle on surfaces quickly, infectious spread may be classified as airborne, or droplet spread.

COVID-19 Outbreaks

First identified in December 2019, COVID-19 is a novel respiratory illness caused by the coronavirus SARS-CoV-2. Individuals infected with COVID-19 are highly contagious and display a wide variety of symptoms, including fever, cough, shortness of breath, and loss of taste or smell. COVID-19 was declared a worldwide pandemic on March 11, 2020, and has affected many aspects of life, including the way care is delivered in congregate settings. COVID-19 is spread through respiratory droplets, which enter the body through the mucous membranes of the nose, mouth, and eyes and quickly infect the lungs. Individuals infected with COVID-19 may be asymptomatic and still contagious for a period of up to 14 days before symptoms develop. It is therefore essential that all staff remain vigilant for signs of infection among residents, staff members, or visitors and that all necessary precautions are adhered to in order to limit the spread of infection within the home should a staff member or resident develop symptoms or be identified as a close contact with a confirmed case of COVID-19.

Why is IPAC Emergency Response Planning Important?

Infectious disease outbreaks occur when one or more individuals within the same setting are infected with a communicable disease that can be transmitted to other individuals. Within a congregate living setting, such as a group home, infectious microorganisms can spread quickly between staff members and residents. It is therefore essential that plans be established with processes for rapid detection of infectious diseases and mitigation of their spread within the facility.

Who is Responsible for IPAC Emergency Response Planning?

Everyone is responsible for outbreak prevention. More specifically, every agency/institution is responsible for creating policies, procedures, and protocols which are clear and accessible and ensure all staff understand their specific roles. Staff are responsible to the agency/institution and most importantly to those in care.

It is strongly encouraged that each agency/institution has a designated Prevention and Control Lead who is responsible for working with their supervisor to ensure the following guidelines and protocols are current and followed:

Outbreak Management Process

IPAC Emergency Response Planning Protocols (e.g., Audit Checklists, Exposure Guidance Flowcharts, Enhanced Cleaning Protocols, etc.)

Managing COVID-19 Outbreaks in Congregate Living Settings (publichealthontario.ca)

MHO Guidance on Cases and Contracts (www.health.gov.on.ca)

COVID-19 Preparedness and Prevention for CongregateLiving Settings (publichealthontario.ca)

When Should IPAC Emergency Response Plans be Implemented?

IPAC Emergency Response Plans should be part of an agency's policy and procedures as a proactive planning and preparedness strategy. Agencies and their staff are encouraged to develop, implement, and practice these plans.

Planning and preparedness strategy should be based on the type of outbreak.

Enteric Outbreak

An enteric outbreak exists at a facility where there are:

Two or more cases meeting the case definition (see below) with a common epidemiological link (i.e., same location, contact with the same individuals, etc.) with initial onset within a 48-hour period.

Case Definition:

Symptoms must not be attributable to another cause (e.g., medication side effects, a pre-existing condition, laxatives, etc.) and **at least one** of the following must be met:

Two or more episodes of diarrhea (i.e., loose/watery bowel movements) within a 24-hour period.

Two or more episodes of vomiting within a 24-hour period.

One or more episodes of diarrhea and **one or more episodes** of vomiting within a 24-hour period.

Respiratory Outbreak

A **suspect respiratory outbreak** exists when you have **at least one** of the following:

Two cases of acute respiratory infection (ARI) as defined by the case definition (see below) occurring within 48 hours with a common epidemiological link (i.e., same location, contact with the same individuals, etc.).
One laboratory-confirmed case of influenza.
A **confirmed respiratory outbreak** exists when you have **at least one** of the following:

Two cases of ARI within 48 hours with a common epidemiological link, at least one of which must be laboratory-confirmed.
Three cases of ARI (laboratory confirmation not necessary) occurring within 48 hours with a common epidemiological link.
Case Definition:

Clinically compatible signs and symptoms in individuals who are part of an outbreak include, but are not limited to:

Upper respiratory tract illness (e.g., common cold, pharyngitis)

Runny nose or sneezing

Stuffy nose (congestion)

Sore or hoarse throat or difficulty swallowing

Dry cough

Swollen or tender glands of the neck

Fever or abnormal temperature

Tiredness

Muscle aches or pain

Loss of appetite

Headache

Chills

COVID-19 Outbreak

Public Health Ontario identifies **COVID-19 outbreaks** in congregate care settings according to the following definition:

An **outbreak** is defined as one or more cases of COVID-19 (as defined by the case definition below) in a resident or staff associated with the facility.

A **possible outbreak** is a cluster of ill residents, staff, and/or visitors (not confirmed to have COVID-19).

CASE DEFINITION:

A. *Probable Case*

A person who:

1. Has symptoms compatible with COVID-19 (see above) and Travelled to or from an affected area (including inside of Canada) in the 14 days prior to symptom onset;

OR

1.a Had a high-risk exposure (i.e., close contact) with a confirmed case of COVID -19

OR

1.b Was exposed to a known cluster or outbreak and In whom a laboratory-based nucleic acid amplification test (NAAT)-based assay (e.g., real-time PCR or nucleic acid sequencing) for SARS-CoV-2 has **not** been completed;

OR

1.c SARS-CoV-2 antibody is detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset.

2. Has symptoms compatible with COVID-19 and In whom a laboratory-based nucleic acid amplification test (NAAT)-based assay (e.g., real-time PCR or nucleic acid sequencing) for SARS-CoV-2 was inconclusive.
3. Is asymptomatic and Had a high-risk exposure (i.e., close contact) with a confirmed case of COVID-19;

OR

a. Was exposed to a known cluster or outbreak.

OR

Is tested with a validated Health Canada-approved point-of-care (POC) NAAT for SARS-CoV-2 and the result is a preliminary positive detected

Isolating-Cohorting and Infection Management Module

Preamble

This module pertains to isolating-cohorting and infection management processes and protocols in congregate care settings.

This module is organized around the following topics:

What is isolating-cohorting?

How are isolating-cohorting processes properly enacted?

Do isolation-cohorting processes depend on the type of setting?

This module consists of the following documents and

sub-folders: Isolating-Cohorting and Infection

Management Learning Outcomes Isolating-Cohorting and

Infection Management Curriculum

Sample Policies for

Implementation Sample

Signage for Public Education

Learning Outcomes for Isolating-Cohorting and Infection Management

After completing this module, participants should be able to:

Define isolating-cohorting and infection management

Describe the typical decision-making processes to determine whether isolating-cohorting is required

Identify how isolating-cohorting prevents the spread of infection

Describe the difference between a low-risk and high-risk setting

Define "symptoms"

Define "close contact"

Isolating-Cohorting and Infection Management Curriculum

This module is organized around the following topics:

What is isolating-cohorting?

How are isolating-cohorting processes properly enacted?

Do isolation-cohorting processes depend on the type of setting?

What is Isolating-Cohorting?

According to Toronto Public Health,"cohorting is used to help prevent the spread of infection in a congregate living setting by grouping individuals separately (e.g., people diagnosed with COVID-19 should be grouped together) in a specific area, such as the same room or on the same floor. Cohorting can help reduce transmission, protect clients and staff, and can be used during outbreak and non-outbreak situations"

Source: https://www.toronto.ca/wp-content/uploads/2021/05/95eb-21-05-10-CohortingCongregateMemov0.01.pdf

How are Isolating-Cohorting processes properly enacted?

The process for enacting isolating-cohorting is best conducted in using a decision tree. Decision trees are regularly used in health-care settings as they ensure accurate interpretation, replication and direction.

To review how a decision tree can be designed to prevent the spread of infection in congregate living settings, please review Empower Simcoe's "Decision Making for Isolating: Step 1, Step 2, Step 3". These decision trees can be accessed in the "Sample Policies for Implementation" folder in the "Empower Simcoe Decision Making Steps 1-3" subfolder.

In particular, please note how the tree provides loop-backs to ensure isolation decisions are made as part of a larger process. Furthermore, it is important to observe the chronological nature of Step 1, Step 2, and Step 3.

Finally, it is worth noting that Step 1 prompts the user to ask a series of questions to establish applicability and the corresponding level of risk. In Steps 2 & 3, the user is provided clear directives on how to respond to each particular scenario. Finally, this

model also provides "Ongoing Instructions" which are useful for reminding users about general principles, policies and procedures related to isolation and cohorting.

Do Isolation-Cohorting Processes Depend on the type of Setting?

Absolutely - isolation-cohorting processes depend on the type of setting. Typically, settings are categorized as either "high risk" or "low risk".

High-risk settings typically include the following:

Group living

Supported independent living

Since each type of setting has its own nuances, it is useful to assess the risk of a setting based on the following criteria:

Interactions:

- Number of interactions
- Proximity of interactions
- Duration of interactions

Location:

- Indoor versus outdoor
- Proximity to hygiene facilities
- Frequency of contact with high-touch surfaces

Agency:

- Effective existing hygiene policies & procedures

Developing a scorecard to assess the degree of risk within a particular environment is a useful strategy to ensure the safety of clients and employees and will help provide direction for developing policies and procedures for mitigating risk.

Personal Protective Equipment (PPE) Module

Preamble

This module pertains to processes and protocols for implementation of (PPE) in congregate care settings.

This module is organized around the following topics:

What is PPE?

Why is PPE required?

When is PPE required?

Which PPE is required in each situation?

How to properly don and doff PPE.

This module consists of the following documents and sub-folders:

PPE Learning Outcomes

PPE Curriculum

Sample Policies for Implementation

Sample Signage for Public Education

Learning Outcomes for Personal Protective Equipment

After completing this module, participants should be able to:

Define personal protective equipment (PPE)

Identify the appropriate PPE for a given situation

Describe when and how to wear PPE

Identify the appropriate PPE to wear after completing a risk assessment and confirming the setting

Describe when PPE needs to be worn, what PPE and when it needs to be changed

Identify the importance of documenting the use of PPE

Identify how to obtain additional information and instructions related to PPE, protocols and procedures

Personal Protective Equipment Curriculum

This module is organized around the following topics:

What is Personal protective equipment (PPE)?

Why is PPE required?

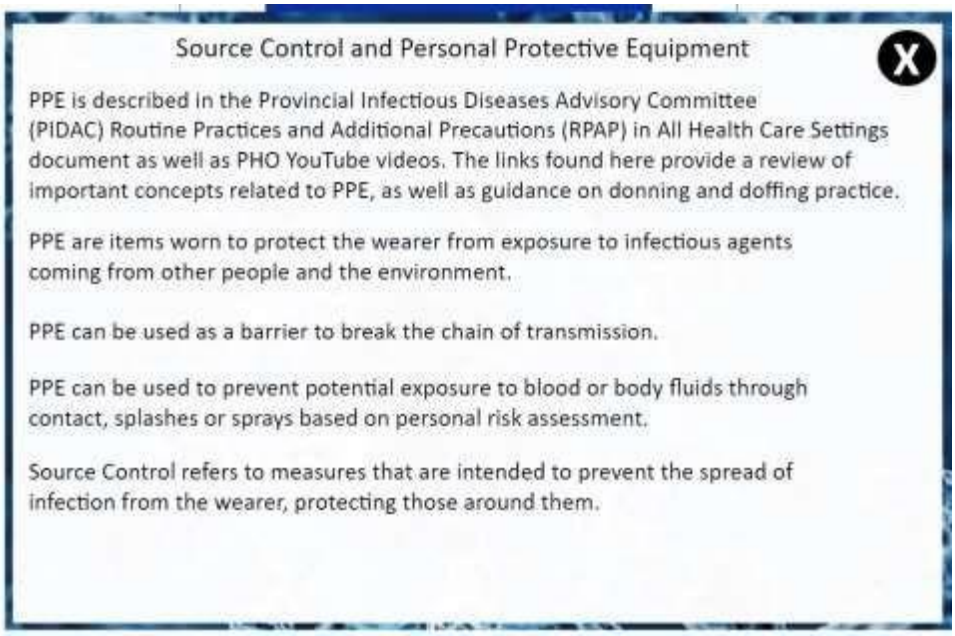
When is PPE required?

What is "appropriate PPE"?

How do you properlydon and doff PPE?

Personal Protective Equipment (PPE) is used to protect the wearer from becoming infected by others. PPE can include one or more of the following types of equipment: medical (surgical/procedure) mask, fit-tested N95 respirator, eye protection (i.e., face shield, goggles, mask with visor attached), gown, and gloves. Cleaning your hands (with

What is PPE?



Source: https://www.publichealthontario.ca/apps/ect/en-ipac-core/main/index.html#/lessons/AD8KSD8AnL24MSV3QFT5QgxfYVG-MaPn

Why is PPE required?

liquid soap and water, or alcohol-based hand rub) is an important part of putting on and taking off PPE.

Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): how to wash your hands/how to use hand sanitizer [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2022 Mar 7].

Masking for Source Control: Wearing a mask (medical masks or non-medical masks such as cloth masks) to protect others from any respiratory infection is source control. The mask is intended to contain infected droplets from the mouth and nose of the wearer so they cannot spread to others. Medical masks meet established filtration standards and are rated to provide good fit and filtration. Cloth masks are less able to provide filtration. Construction of medical masks may be variable, but are made with 3 layers of material to optimize filtration.

Source: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/covid-19-ppe-non-medical-masks-congregate-living-settings.pdf?la=en

Which PPE are required in each situation?

The PPE staff should wear is based on personal risk assessment including:

The type of direct care that is being provided to the resident (direct care may include helping with feeding, bathing, washing, turning, changing clothing, toileting and wound care)

The health status of the resident.

The direction received from public health, governing ministry or your organization

(Source: Ontario Agency for Health Protection and Promotion (Public health Ontario). Interim IPAC recommendations for use of personal protective equipment for care of individuals with suspect or confirmed COVID-19 [Internet]. Toronto, ON: Queens's Printer for Ontario; 2022 [modified 2022 Mar; cited 2022 April 1].

Another factor that should be considered regarding which PPE is required is the status of outbreak in the facility and the corresponding area.

No Outbreak in the Facility

Based on the type of direct care that is being provided to the resident, the health status of the resident, or the direction received from public health, governing ministry or your organizations policies and procedures, staff and visitors should wear a mask for source control. The selection of PPE is based on the personal risk assessment.

Facility in Outbreak: Non-Outbreak Area

Staff and essential visitors should wear a medical mask at all times during a shift, with or without eye protection, based on advice from the local public health unit, except: When eating (when staff should stay 2 meters from others) or when alone in a private space. As per recommended practice, wear appropriate PPE when providing direct care such as helping with feeding, bathing, washing, turning, changing clothing, toileting, and wound care to a resident.

The selection of PPE is based on the personal risk assessment.

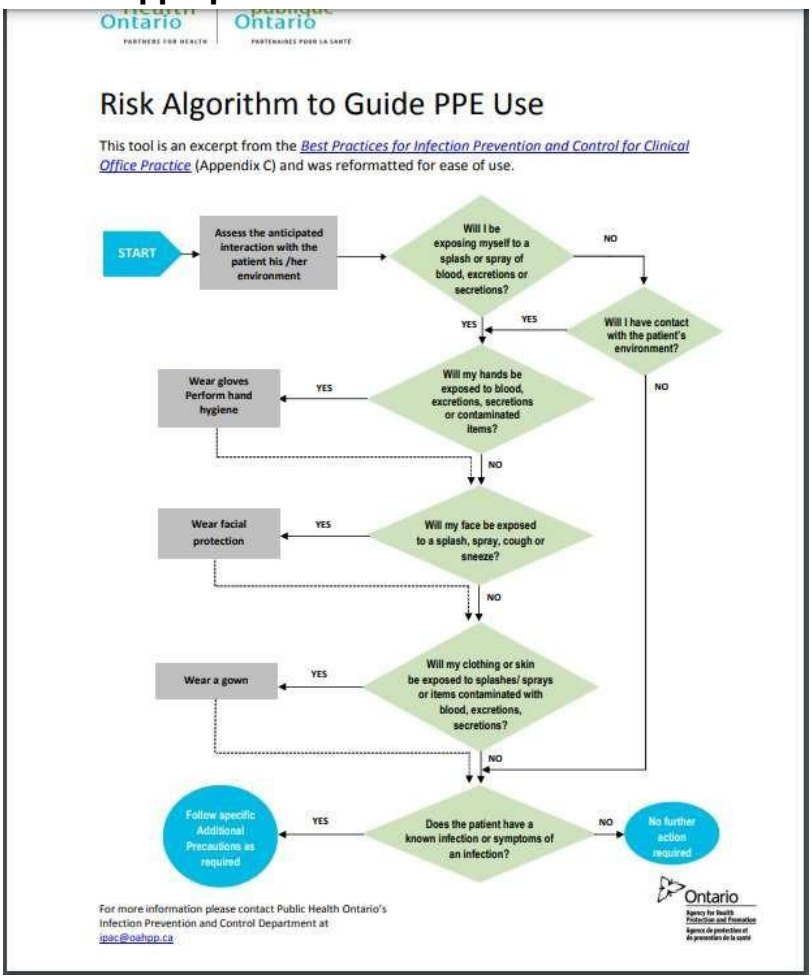
Facility in Outbreak: Outbreak Area

Wear a medical mask at all times, except when eating (when staff should stay 2 meters from others) or when alone in a private space. Eye protection and gowns are added when resident interactions take place within the outbreak area. Gloves are also added when providing direct care such as helping with feeding, bathing, washing, turning, changing clothing, toileting, and wound care to a resident.

As per recommended practice, wear appropriate PPE when providing direct care such as helping with feeding, bathing, washing, turning, changing clothing, toileting, and wound care to a resident.

The selection of PPE is based on the personal risk assessment. All PPE should be removed after use, before supporting different residents, and when moving between areas of the congregate setting. PPE should be changed as per recommendations in Cohorting in Outbreaks in Congregate Living Settings. There should be a equipped and designated area for this donning and doffing of PPE.

What is "appropriate PPE"?



Source: https://www.publichealthontario.ca/-/media/documents/c/2013/clinical-office-risk-algorithm-ppe.pdf?la=en

How do you properly don and doff PPE?

Putting on Full PPE

Taking off Full PPE

Source: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/covid-19-ppe-non-medical-masks-congregate-living-settings.pdf?la=en

Screening Protocol Module

Preamble

This module pertains to the screening processes and protocols in congregate settings.

This module is organized around the following topics:

What is screening?

Why is screening in congregate settings required?

When is screening required?

Who requires screening?

How is the screening conducted?

This module consists of the following documents and sub-folders:

Screening Protocol Learning Outcomes

Screening Protocol Curriculum

Sample Policies for Implementation

Sample Signage for Public Education

Learning Outcomes for Screening Protocol

After finishing this screening module, you will be able to:

Implement screening as directed

Differentiate between active and passive screening

Understand signs and symptoms of respiratory and gastrointestinal illnesses

Determine who requires screening and when screening should be conducted

Differentiate methods of conducting screening and rapid antigen testing Manage client, staff and visitor illnesses

Screening Protocol Curriculum

This module is organized around the following topics:

What is screening?
Why is screening in congregate settings required?
When is screening required?
Who requires screening?
How is screening conducted?

What is Screening?

There are two types of screening: 1) active screening and 2) passive screening.

Active screening: means that the employer must collect and review information to actively determine whether a person may enter the workplace.

Passive screening: occurs when employees assess their own risk factors and decide for themselves whether they may enter the workplace or not. Passive screening through signage should be posted onsite prompting anyone on site to self-identify if they feel unwell.

Screening involves questions about symptoms and exposure to determine if a person is likely to be infectious. A person passes screening if they have none of the symptoms or exposures asked about in the screening tool.

Source: https://www.ontario.ca/page/screening-covid-19-guidance-employers

Screening self-assessment: https://covid-19.ontario.ca/self-assessment/

Are you currently experiencing one or more of the following symptoms that are new or worsening?

Fever and/or chills

Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher

Cough or barking cough (croup)

Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have

Shortness of breath

Not related to asthma or other known causes or conditions you already have

Decrease or loss of taste or smell

Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have

(For adults > 18 years or older)

Fatigue, lethargy, malaise and/or myalgias*

Unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)

(For children < 18 years)

Nausea, vomiting and/or diarrhea

If you answered "yes" to any of these questions, please do not enter.

Go home immediately and contact your healthcare provider or Public Health for further instructions.

Thank you for doing your part to keep us safe!

*If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, answer "No."

COVID-19 Contact Screening Questions

In the last 14 days...

Have you travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements?

Has someone in your household (someone you live with) travelled outside of Canada AND been advised to quarantine (as per the federal quarantine requirements)?*

In the last 10 days...

Have you been identified as a "close contact" of someone who currently has COVID-19?*

Has someone in your household (someone you live with) been identified as a "close contact" of someone who currently has COVID-19 AND advised by a doctor, healthcare provider or public health unit to self-isolate?*

Have you received a COVID Alert exposure notification on your cell phone?*

Have you tested positive on a rapid antigen test or a home-based self-testing kit?

Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?*

*If you are fully immunized or have tested positive for COVID-19 in the last 90 days and since been cleared, answer "No."

If you answered "yes" to any of these questions, please do not enter.

Go home immediately and contact your healthcare provider or Public Health for further instructions.

Thank you for doing your part to keep us safe!

Why is Screening Required?
Screening should be implemented to control potential exposure to infectious diseases in your workplace.

Screening helps keep infected workers and others from entering the workplace; it can help to reduce transmission at work. Screening can never ensure completely the possibility that somebody is unknowingly infectious.

When is Screening Required?
Screening is required when directed to do so by agency policies and procedures, or by public health or another authority.

Who Requires Screening?
Depending on agency policies and procedures or directives, clients, staff, and visitors may require screening. For example, During the Covid-19 pandemic, all persons seeking entry into a congregate living setting were required to be actively screened for symptoms and exposure history, regardless of their vaccination status. This included all staff, visitors and clients returning from absence.

Symptom Assessment of Clients

All clients in the congregate living setting should be assessed once daily to identify any new or worsening symptoms. Congregate living settings should be aware that some clients (i.e. elderly, young children, non-verbal individuals) may present with subtle of atypical signs and symptoms.

Source:https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_congregate_living_guidance.pdf

How is Screening Conducted?
Question-based screening involves questions about symptoms and exposures and the answers given will determine if the person if infectious or likely to be infected and ultimately determine if they can enter the workplace.

Question-based screening may be done in-person or remotely and may include:

Over the telephone
Web tool or app
Email
Paper-based
Signs with clear instructions at all entrances that tell people how to screen themselves

Rapid antigen screening involves collection of a sample from an individual that is analyzed to see if it contains infection. Results for rapid antigen screening are usually analyzed and available in 15 minutes.

A person has passed rapid antigen screening if they get a negative result on the rapid antigen test. Individuals with a positive result obtained through a rapid antigen screening should leave the setting immediately and follow the appropriate public health directive.

Respiratory Etiquette

Preamble

This module pertains to Respiratory Etiquette in congregate care settings.

This module is organized around the following topics:

What is respiratory etiquette?

Why is respiratory etiquette required?

When is respiratory etiquette required?

How is respiratory etiquette completed?

This module consists of the following documents and sub-folders:

Respiratory Etiquettes Learning Outcomes

Respiratory Etiquettes Curriculum

Sample Policies for Implementation

Sample Signage for Public Education

Learning Outcomes for Respiratory Etiquettes

After completing this module, participants should be able to:

Define Respiratory Etiquette

Identify the appropriate methods of Respiratory Etiquettes for a given situation

Describe when and how to practice Respiratory Etiquette

Identify the importance of Respiratory Etiquettes as it relates to the reduction in infection prevention and control

Respiratory Etiquette

This module is organized around the following topics:

What is respiratory etiquette?
Why is respiratory etiquette required?
When is respiratory etiquette required?
How is respiratory etiquette completed?

What is Respiratory Etiquette?

According to Public Health Ontario the practices that help in preventing the spread of various bacteria and viruses that cause acute respiratory infections are called respiratory etiquette.

Why is Respiratory Etiquette Required?

According to Centers for Disease Control and Prevention, Respiratory etiquette is required to avoid the transmission of respiratory illness. Respiratory illness is transmitted through the microorganism in droplets produced while coughing or sneezing. Key standard precautions to reduce the spread of respiratory illness are;

1. Performing actions to stop the spread of respiratory infections from residents and visitors who exhibit symptoms or signs of illness while they are in the congregate care setting.
    - Putting up signs at entrances for residents and visitors to check for respiratory illness.
    - Providing tissue and no touch bin to dispose.
    - Proving hand hygiene resources.
    - Offering masks to symptomatic residents and visitors of the setting.

2. Informing Public Health if there is a respiratory Infection outbreak.

Source: https://i.pinimg.com/736x/f5/7f/e5/f57fe55c344e4aebc17e86ae4b075c93.jpg

When is respiratory etiquette required?

Respiratory etiquette is required at ALL times to prevent the transmission of respiratory diseases. It is highly recommended to put **Visual Alerts** at the entrance to raise awareness and be alert for any symptoms of respiratory illness.

Follow proper **respiratory etiquette and cough hygiene.**

VISUAL ALERTS

There should be posters in language that is easy to understand and accessible to staff and visitors. If staff, visitors or residents have any symptoms they should inform about it and follow proper respiratory hygiene and cough etiquette.

Source: https://www.postertemplate.co.uk/wp-content/uploads/2018/07/colour-cough-poster-1-212x300.png

How do you Perform RESPIRATORY HYGIENE/ COUGH ETIQUETTE

Whenever you cough or sneeze, cover your mouth and nose with a tissue. Use the tissue, then throw it away in the closest trash.

After encountering respiratory droplets and contaminated objects or materials, practice hand hygiene by washing your hands with non-antimicrobial soap and water, using alcohol-based hand rub, or an antiseptic handwash.

Healthcare facilities should make sure that there are resources available in waiting rooms for patients and visitors to follow respiratory hygiene/cough etiquette. Provide tissues and no-touch trash cans for disposed of used tissues.

Dispensers of alcohol-based hand sanitizer should be placed in convenient areas, and where sinks are provided, materials for hand washing (such as soap and paper towels) should always be accessible.

Source: Respiratory Hygiene/Cough Etiquette in Healthcare Settings | CDC

How is respiratory etiquette completed?

Respiratory etiquette is completed when proper care and hygiene is maintained. Proper hygiene is maintained by covering face while coughing and sneezing, washing hands with soap or alcohol-based hand rub. Some of the other things that should be taken care of is **making separation of persons with respiratory symptoms** to avoid the spread of infection.

MAKING AND SEPARATION OF PERSONS WITH RESPIRATORY SYMPTOMS

During the period of increased respiratory illness, infections arrange proper N95 or surgical masks to provide people, who are coughing. If possible, arrange seats at a distance of 3 feet and space in waiting areas.

DROPLET PRECAUTION

Encourage medical staff to use Droplet Measures (i.e., wear a surgical or procedural mask for close contact) along with Standard Precautions while assessing a patient exhibiting signs of a respiratory disease, especially if a fever is present.

Source: Respiratory Hygiene/Cough Etiquette in Healthcare Settings | CDC

Disposal of Waste and Linen Cleaning

Preamble

This module pertains to Disposal of Waste and Linen Cleaning in congregate care settings.

This module is organized around the following topics:

What is disposal of waste and linen cleaning?

Why is disposal of waste and linen cleaning required?

How is disposal of waste and linen cleaning completed?

This module consists of the following documents and sub-folders:

Disposal of waste and linen cleaning curriculum

Disposal of waste and linen cleaning outcomes

Learning Outcomes for Disposal of Waste and Linen Cleaning

After completing this module, participants should be able to:

Define Disposal of Waste and Linen Cleaning

Identify the appropriate methods of Disposal of waste and linen cleaning for a given situation

Describe when and how to practice disposal of waste and linen cleaning

Identify the importance of disposal of waste and linen cleaning as it relates to the reduction in infection prevention and control

Disposal of Waste and Linen Cleaning

This module is organized around the following topics:

What is disposal of waste and linen cleaning?
Why is disposal of waste and linen cleaning required?
How is disposal of waste and linen cleaning done?

What is disposal of waste and linen cleaning?

According to Public Health of Ontario, Waste is divided into categories in health care settings which is known as "biomedical waste". This waste has different categories and has to be handled according to the municipal laws of the area.

Source: https://www.publichealthontario.ca/-/media/documents/I/2021/ipac-ltch-principles-best-practices

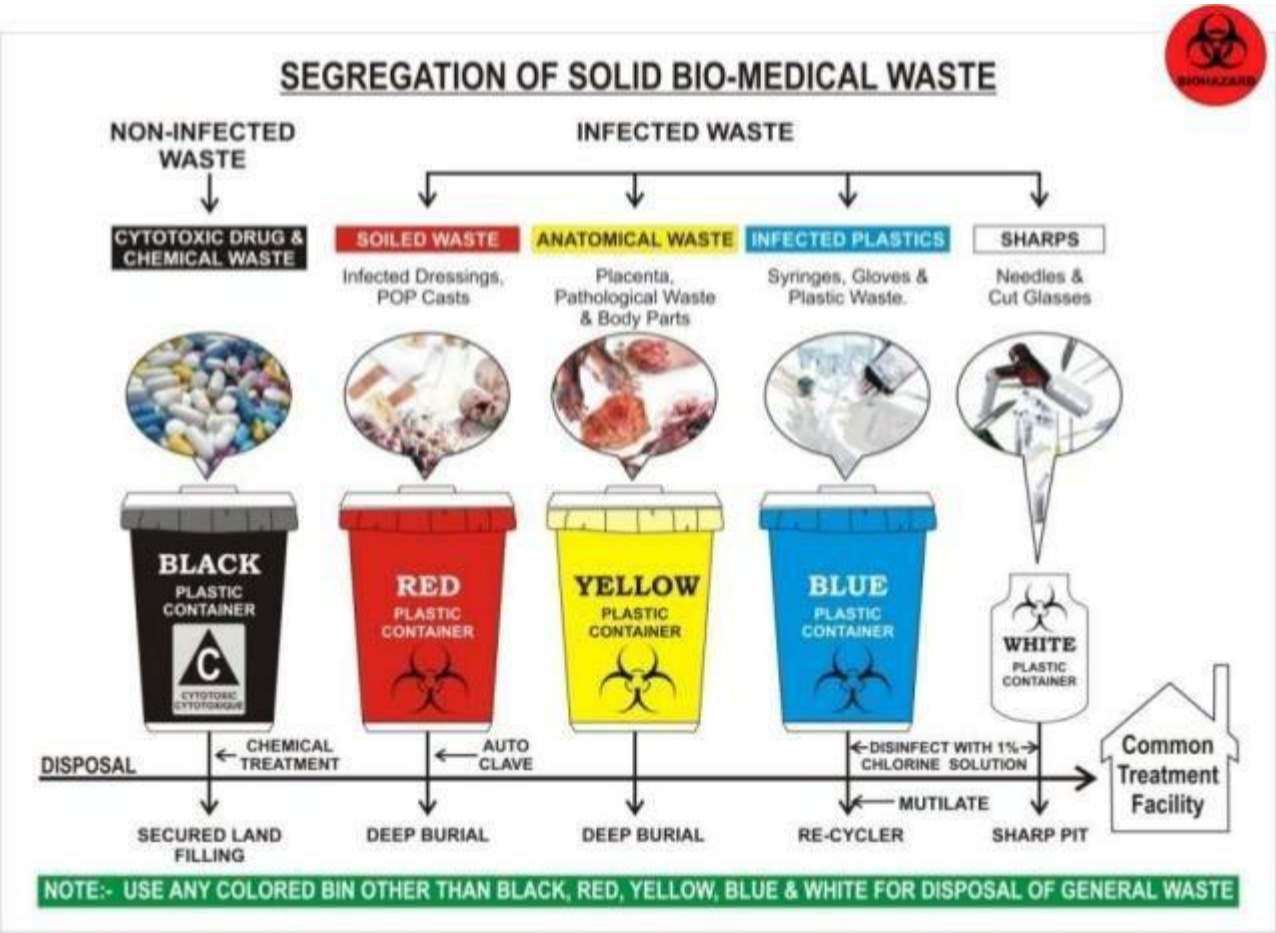
Why is Disposal of waste and Linen Cleaning Required?

Waste in healthcare settings mainly consists of human anatomical waste, human and animal cultures and specimens, human liquid blood and blood products, items contaminated with blood or blood products that would release liquid or semi-liquid blood if compressed or squeezed, body fluids visibly contaminated with blood, sharps and broken glass that has come into contact with blood or body fluid.

Therefore, proper disposal of waste is very important to avoid spread of infections or bacteria. In a health care setting there are five different disposal streams. These five different disposal streams, require special handling and has specific color bag associated with a particular category.

Despite the rarity of links between contaminated linen and infection, it must be treated carefully throughout collection, transit, washing, and drying. When handling soiled linen, health care professionals must conduct a risk assessment to decide when and how to utilize personal protection equipment and when to practice hand hygiene. No matter whether the linen is polluted with blood or bodily fluids, it must be handled in the same way as a matter of course. Watch out for sharps concealed in linen! A health and safety issue must be reported if sharps are discovered in linen. Sharps handling requires the use of safe procedures.

Source: IPAC Core Competencies – Control of the Environment (publichealthontario.ca)



Source:https://th.bing.com/th/id/R.8b4e48f2a37c0bf05c94fbc32273f0ad?rik=jqoPWOp7PWCFVA&riu=http%3a%2f%2fwww.asantewm.com%2fwp-content%2fuploads%2f2016%2f07%2f18.png&ehk=F0Ojq2RMwt10e71hCsMRxhsLzOPkMEAPL1zc6s4YENg%3d&risl=&pid=ImgRaw&r=0

How is Disposal of Waste and Linen Cleaning done?

Handling Waste

Conduct a risk evaluation and, if necessary, wear personal protection equipment when handling waste to keep yourself safe. For instance, you might have to put on gloves.

The disposal of trash that contains blood that could spill when squeezed or compressed requires the use of a biomedical waste or yellow bag.

If you accidentally put sharps in the bag, you run a higher risk of suffering a sharps injury if you compress or squeeze the material of the bag.

The bag will be more prone to break if you fill it up too much. When the bag is three-quarters full, zip it up.

To prevent the contents of the bag from spilling, tie the bag tightly before transporting.

Except in cases when the initial bag becomes ripped or broken, it is not necessary to double-bag waste.

Cleaning of Linens

In addition to policies and procedures for handling clean and soiled linen, your business should also give instruction and training in safe linen handling. You will be better protected from infectious pathogens as a result.

How to deal with filthy linen is as follows:

- Put on personal protection gear in accordance with your risk assessment.
- Soiled linen should be handled away from your body, rolled up, and bagged at the source.
- Wet linen should be contained in a dry sheet or towel before being placed in the linen bag.
- Gross soil should be removed with a gloved hand and disposed of in the toilet or hopper.
- Soiled linen should be placed in the linen bag gently without shaking it.
- Do not overfill bags; instead, tie them tightly.
- Avoid touching your body with bags, hold them by the knot, don't double-bag linen, and don't use water-soluble bags.

Source: https://www.publichealthontario.ca/-/media/documents/i/2020/ipac-core-accessible-coe-course.pdf?la=en&sc_lang=fr&hash=CD0FC234D6C5BFFC3995809454E32622-

Visiting Forms Module

Preamble

This module pertains to Visiting Forms in congregate care settings.

This module is organized around the following topics:

What are Visiting hours?

When do you consider visits?

Why use Visiting Forms?

How is the process?

What are the requirements for absence from care facility?

Examples of absence forms, visitor forms and virtual visitor forms

This module consists of the following documents and sub-folders:

Visiting Forms Curriculum

Visiting Forms Learning Outcomes

Sample Policies for Implementation

Sample Signage for Public Education

Learning Outcomes for Visiting Forms

After finishing this module, participants will be able to:

Define Visiting hours

Understand the different types of visits

Define a Visiting form

Identify the process of visiting care homes

Describe the requirements for an absence form

View examples of absence and visiting forms

Identify Virtual visitor form

Visiting Forms Curriculum

This module is organized around the following topics:

What are Visiting hours?
When do you consider visits?
Why use Visiting Forms?
How is the process?
What are the requirements for absence from care facility?

What are visiting hours?

In an institution such as a hospital, or care homes, visiting hours are the times during which people from outside the institution are officially allowed to visit people who are staying at the institution.

When do you consider visits?

Essential visits are necessarily linked with an essential need that could not be met in the absence of the essential visit. Facility staff will determine if a visit is essential.

An essential visit includes:

Visits for compassionate reasons including critical illness,

Visits are paramount to the resident's physical care and mental well-being (e.g., assistance with feeding, mobility, personal care, or communication assistance by designated representatives for persons with disabilities)

Visits for supported decision-making.

Existing registered volunteers providing the services described above.

Visits required to move belongings in/out of a resident's room; and

Police, correctional officers, and peace officers accompany a resident for security reasons.

Essential visits are permitted in a care facility that has an active COVID -19 outbreak, under guidance and direction from the local medical health officer.

A single designated visitor is the person who a resident has been supported to identity, who may continue to visit the resident at times when visitation is restricted. Single designated visitors are permitted in a care home/residence that has an active COVID-19 outbreak, under guidance and direction from the local medical health officer.

Single designated visitors should be documented in the resident's record as part of the resident's care planning.

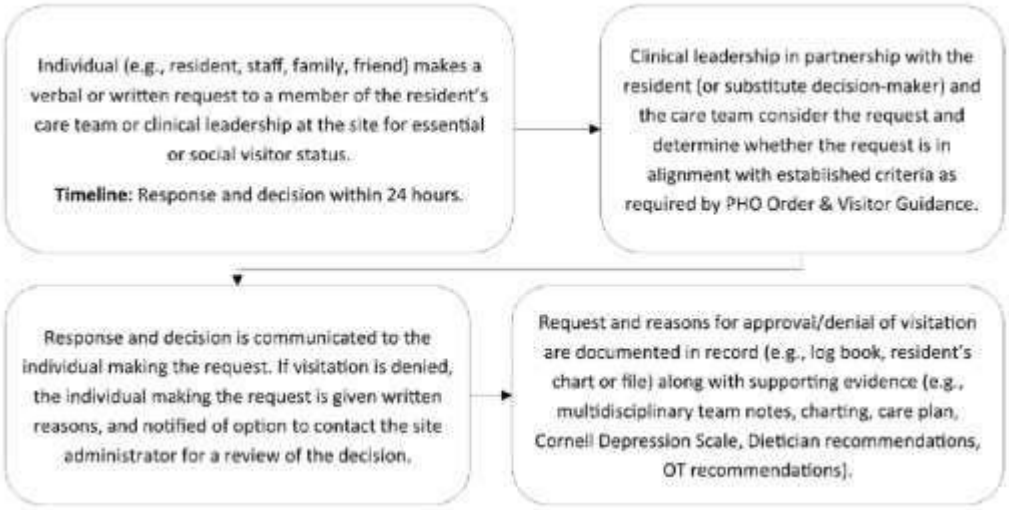
Operators will support resident requests to identify an alternate single designated visitor should there be extenuating circumstances such as where the single designated visitor falls ill or moves.

Social visits are visits other than essential visits or visits from a single designated visitor where the primary purpose is to provide opportunities for residents to spend time with loved ones to support their social, spiritual, and emotional wellbeing.

Why use visiting forms?

Visiting forms are filled out by the people who want to visit someone within the institution. These forms provide you with details about who is visiting, the purpose of their visit, and if they are there to see a specific person. More and more businesses are replacing their paper sign-in sheets with mobile forms, as it is not only much more efficient to store and maintain records for, but also extremely easy to search on and analyze. These forms capture important data that you can analyze to learn more about your business, customers and office security.

How is the process?



What are the requirements for absence from care facility?

Requirements

All congregated care facilities must establish and implement policies and procedures in respect of resident absences, which, at a minimum set out the definitions and requirements and conditions described below.

For **all absences**, residents must be:

provided with a medical mask when they are leaving the home

provided a handout that reminds residents and families to practice public health measures such as masking and hand hygiene when outside of the home

actively screened upon their return to the facility

There are four types of absences:

medical absences are absences to seek medical or health care and include:

outpatient medical visits and a single visit (less than or equal to 24 hours in duration) to the emergency department

all other medical visits (for example, admissions or transfers to other health care facilities, multi-night stays in the emergency department)

short term (day) absences are absences that are less than or equal to 24 hours in duration and include:

social absences include absences for all reasons not listed under medical, compassionate or palliative, or essential absences that do not include an overnight stay

temporary absences include absences involving two or more days and one or more nights for non-medical reasons

As per Directive #3 (PDF), homes cannot restrict or deny absences for medical, palliative or compassionate reasons at any time. This includes when a resident is in isolation or when a home is in outbreak.

Day trips and vacation

Residents may leave their long-term care home for various reasons, including:

daytime outings

vacations to visit family or friends

to remain active in the community

These outings have time limits.

Casual absences should not exceed 48 hours per week.

Vacation absences should not exceed 21 days., Residents planning to take a day trip or a short vacation may also be subject to additional public health measure

Source: COVID-19 guidancedocument for long-term care homes in Ontario | ontario.ca

Absence Form Example:

Carmel, IN 46082-1902

FACILITY LEAVE OF ABSENCE FORM

This form is intended to be completed in regards to a resident in your facility who has an established claim for long or short term care benefits. Please complete the information below in regards to absences of the facility resident in full and submit along with the current facility bill. This will assist us in servicing your resident's claim quickly and reduce the need for clarifying phone calls.

RESIDENT/PATIENT NAME:

_____

POLICY NUMBER:

_____ Date: _____

Please return completed form with the current bill to:
Policy Benefits Department
PO Box 1902
Carmel IN 46082-1902

Or fax this form and the current bill to:
Policy Benefits Department
312-396-5952

Please note: the form must be completed, signed, and dated no sooner than the 25th of each month to consider benefits for that month.

1. Billing Period (Attach billing invoice): From: _____/_____/_____ To: _____/_____/_____
   If the resident is deceased or discharged from care, please provide date: _____/_____/_____
   Was the resident charged for the date of death/discharge date? ☐ Yes ☐ No
2. Was the Resident/Patient absent from the facility overnight at any time during this billing period?
   ☐ Yes ☐ No If Yes, please fill out below sections.
   Hospital Stay: Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____
   Was the resident charged for either day? ☐ Yes ☐ No If Yes, which date(s) _____
   Bed Hold Charge? ☐ Yes ☐ No If Yes, daily amount: $ _____
   Other Overnight Absence: Reason _____
   Departure Date: _____/_____/_____ Return Date: _____/_____/_____
   Was the resident charged for either day? ☐ Yes ☐ No If Yes, which date(s) _____
   Bed Hold Charge? ☐ Yes ☐ No If Yes, daily amount: $_____
3. Is Medicare, Medicaid, or any other insurance providing benefits for services during this period?
   ☐ No ☐ Yes, Medicare ☐ Yes, Medicaid ☐ Yes, Other governmental insurance
   Please provide dates of 100% coverage / coinsurance coverage / private pay below. Please include EOB or UB94 along with the bill and this form.
   _____
   _____
   _____
4. If your facility has multiple levels of care, in which section does the resident reside?
   ☐ Skilled Nursing Facility ☐ Intermediate Care Facility ☐ Assisted Living Facility
   ☐ Alzheimer's Unit (in ALF) ☐ Independent

Name of Facility: _____ Phone Number: _____

Name of person completing this form: _____ Title: _____

Signature: _____ Date: _____/_____/_____

PLEASE SUBMIT A COPY OF THE BILL WITH THIS FORM

Visitor Form Example:

Note: Visits in the community (e.g., in parks, at restaurants, at the mall, a short day visit to a family member's home, etc.) are tracked in Support Notes, not on the Visiting Record form. If people using services go into the community, teams can help support or encourage them to track who they have been in contact with and where they have gone using the Where I've been Timeline tracker. This tracker will help people who use our services to retrace their steps and track their contact with others, in the event they feel sick or develop symptoms.

Name of Person Supported: | Location:

TYPE OF RECORD:		
☐	ESSENTIAL RE-OCCURRING VISIT	*Planning for visits at Christian Horizons support locations*
☐	OVERNIGHT VISIT	*Staying with family or friends overnight*
☐	NON-ESSENTIAL FAMILY/FRIEND OR ONE-TIME ESSENTIAL VISIT	*Single use tracking for infrequent visits at Christian Horizons support locations*

ESSENTIAL RE-OCCURRING VISIT

For **essential re-occurring visits** at Christian Horizons support locations, this record is to be completed and approved **ONCE** in advance of the first visit. Documentation of subsequent visits is to be recorded in Support Notes. Active screening for every visit will continue to be tracked on the Screening Tracking Form. If and when there is a change in essential visitors, complete a new Visiting Record to document the change.

Date of First Visit | Start Time | End Time

Visitor Name | Contact Information

Second Visitor Name (if applicable) | Contact Information

Purpose for visits:

Outline the anticipated frequency of visits if they follow a consistent schedule (e.g., each Tues morning, 3rd Monday of each month at 1:00 PM, etc.)?

☐ Employee(s) confirmed they have reviewed the visit requirements as outlined in the COVID-19 Visiting Guide for Locations with the visitors prior to initial Essential Re-Occurring visit.

☐ Visitors confirmed they understand the different requirements MCCSS have in place for visits where all parties are fully vaccinated and visits where not all parties are fully vaccinated. The visitors also acknowledged that they will follow the guidance that is appropriate to their situation during the visit.

COVID-19 VISITING RECORD (ONTARIO) ChristianHorizons

General notes/comments about the visit:

Name of Employee Completing the Form | Date Record Completed

Name of Supervisor Reviewing/Approving | Date Reviewed/Approved

OVERNIGHT VISIT

To be completed for **EVERY** overnight visit occurring outside of Christian Horizons support locations.

PRE-VISIT:

Visit Start Date | Start Time | Visit End Date | End Time

Family/Friend Name (Main Contact) | Contact Information

☐ Families or friends have received COVID-19 Visiting Guide for Families and Friends and Going Out Safely Guide, and have been made aware of MCCSS Guidelines for Overnight Visits including following enhanced precautions 14 days upon returning from overnight visits for people using services who are not fully vaccinated.

☐ Families or friends have received a copy of the Where I've Been Timeline tracker and are reminded to support their loved one to trace contacts by completing this tracker in the event of possible COVID-19 exposure.

☐ Employees have confirmed that both the person and their family member(s) or friend(s) have been actively screened for signs and symptoms of COVID-19 using Christian Horizons Screening Protocol before an overnight visit commences.

POST-VISIT:

Please note any updates or issues/concerns that have arisen regarding the visit:

☐ Employee received a completed copy of the **Where I've Been Timeline** tracker following the overnight visit.

☐ The person returning home following an overnight visit was actively screened for signs and symptoms of COVID-19 before entry and supported to get tested, if the person wishes.

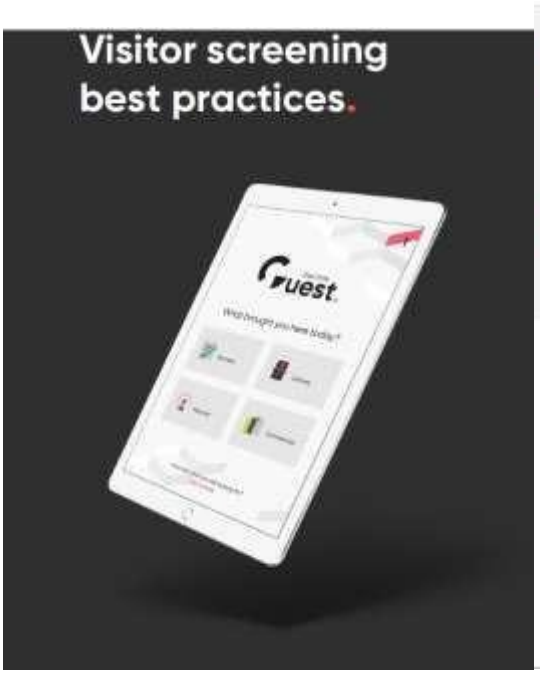
☐ The person, who is not fully vaccinated, returning home from an overnight visit is being supported to follow the 14-days of enhanced precautions.

Name of Employee Completing the Form | Date Record Completed

Supervisor Review/Approval | Date Reviewed/Approved

An example of Virtual Visitor Form:

[Visitor Management for Senior CareHomes | Traction Guest]



QUESTIONS

CLEANING AND DISINFECTING

1. Cleaning refers to the process of using soap or detergent to remove dirt and germs from surfaces. It does not kill germs.
   True
   False

2. Microorganisms can survive for a long period of time which allows transmission.
   True
   False

HAND HYGIENE

3. Hand hygiene refers to the removal of visible soil from hands. True
   False

4. Alcohol-based hand rub should be used when hands are not visibly soiled.
   True
   False

IPAC EMERGENCY RESPONSE PLANS

5. Enteric outbreak consists of:
   a. Two or more episodes of diarrhea within 24 hours.
   b. Two or more episodes of vomiting within 24 hours.
   c. All of the above

6. An **outbreak** is defined as one or more cases of any identifiable illness (such as COVID-19) in a resident or staff associated with the facility.
   True
   False

ISOLATING-COHORTING AND INFECTION MANAGEMENT

7. Isolation and Cohorting processes depend on the type of Setting.
   True
   False

PERSONAL PROTECTIVE EQUIPMENT

8. Personal Protective Equipment (PPE) is used to protect the wearer from becoming infected by others and others from being infected by the wearer.
   True
   False

9. PPE consists of;
   a. Eye protection
   b. Facial mask- N95 rating preferred, eye protection, gown and gloves

SCREENING PROTOCOL

‘

10. Screening questions can be asked on the telephone.
    True
    False

11. Screening is required when directed to do so by agency policies and procedures, or when directed by an authority such a s public health
    True
    False

RESPIRATORY ETIQUETTE

12. Respiratory etiquette is defined as-
    a. saying "excuse me" when you cough or sneeze
    b. covering mouth with elbow when you cough to limit droplet spread
    c. wearing a mask at all times
    d. All of the above

DISPOSAL OF WASTE AND LINEN CLEANING

13. The disposal of trash containing blood that could spill when squeezed or compressed requires the use of a biomedical waste or red bag.
    True
    False

14. Soiled linen should be handled away from your body, rolled up, and bagged at the source.
    True
    False

Answers

1. True
2. True
3. False
4. True
5. C. All of the above
6. True
7. True
8. True
9. b. N95 mask, eye protection, gown and gloves
10. True
11. True
12. D. All of the above
13. False
14. True