Prince Edward Island
CANADA
Health and Wellness

Prince Edward Island Guidelines for Infection Prevention and Control of COVID-19 in Community Care Facilities

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Department of Health and Wellness
Chief Public Health Office

Contents

Executive Summary

This document provides foundational guidance specific to the COVID-19 pandemic in Community Care Facilities (CCF).

Individuals responsible for policy development, implementation and oversight of infection prevention and control measures at specific Community Care Facilities should be familiar with relevant infection prevention and control for routine practices and additional precautions and occupational health and safety legislation. The term "staff" is intended to include anyone working in CCF, including but not limited to health care workers.

Important measures to prevent introduction and spread of COVID-19 in CCF:

- Visitors should be restricted to those deemed essential for the functioning of the facility e.g. food delivery, supplies etc. Visitors may also be permitted for compassionate reasons (e.g. end of life).

- All staff and residents must be trained on infection control measures such as proper hand hygiene (Appendix A), Contact and Droplet precautions, personal protective equipment (PPE) donning and doffing procedure (Appendix B) and the importance of maintaining a two (2) metre, or six (6) foot spatial distance between residents.

- All staff must work to identify suspect or confirmed cases of COVID-19 as early as possible in staff or residents.

- If there is a COVID-19 case in a facility, staff who are employed in more than one healthcare facility should not move from a COVID-19 outbreak facility to a non-COVID-19 outbreak site.

- Facility management must identify all staff that work in more than one location (e. g. LTC facilities, community care). Ensure efforts are made to prevent this where possible in order to limit spread between facilities and to inform investigations during an outbreak.

- Dual CC and LTC facilities will refer to the PEI Guidelines for Infection Prevention and Control of COVID-19 in Long Term Care Facilities for guidance and management of COVID-19.

Introduction

Infection prevention and control strategies to prevent or limit transmission of COVID-19 in CCF are similar to those used for the infection prevention and control (IPC) of other acute respiratory infections, including:

- Prompt identification of all persons with signs and symptoms of possible COVID-19.
    - Signs or symptoms may include:
        - Fever, single temp >37.8C
        - Any new or worsening respiratory symptoms (cough and/or shortness of breath, runny nose, sneezing or nasal congestion, hoarse voice, sore throat or difficulty swallowing), **OR**
        - Any new onset non-respiratory symptoms including chills, muscle aches, diarrhea, malaise, headache, or other unexplained symptoms or change in clinical status.

Infection Prevention and Control (IPC)

Hand Hygiene

Hand hygiene (Appendix A) refers to cleaning hands with soap and water or the use of an alcohol-based hand rub (ABHR). Hand hygiene should be performed frequently and at the following times;

Staff:

- On entry to and exit from the CC facility
- Before and after contact with a resident, regardless of whether gloves are worn
- Before putting on and after removing gloves
- Before and after contact with the resident's environment (e.g. medical equipment, bed, table, door handle) regardless of whether gloves are worn
- Any other time hands are considered to be potentially contaminated (e.g. after handling blood, body fluids, bedpans, urinals, or wound dressings)
- Before preparing or administering all medications or food
- After other personal hygiene practices (e.g. blowing nose, using toilet facilities, etc.)

Residents:

- Upon entering or leaving their room
- Prior to: eating, oral care, or handling of oral medications
- After using toileting facilities
- Any other time hands are considered to be potentially soiled

If soap and water are not available, hands can be cleaned with an alcohol-based hand sanitizer (ABHR) that contains at least 60% alcohol, ensuring that all surfaces of the hands are covered (e.g. front and back of hands as well as between fingers) and rubbed together until they feel dry.

Touching one's eyes, nose, and mouth with unwashed hands should be avoided.

Respiratory Etiquette

Respiratory etiquette describes measures intended to reduce transmission of COVID-19 when an ill person is coughing, sneezing and talking.

- Cover coughs and sneezes using a tissue. Dispose of tissues in a lined waste container and perform hand hygiene immediately after a cough or sneeze

  OR
- Cough/sneeze into the bend of your arm, not your hand.

Environmental Cleaning

Cleaning the co-living setting: Frequently touched areas such as toilets, bedside tables, light switches and door handles should be first cleaned (to physically remove dirt) and disinfected daily with regular household cleaning products or a diluted bleach solution (0.5% sodium hypochlorite). If they can withstand the use of liquids for disinfection, frequently touched electronics such as phones, computers and other devices may be disinfected with 70% alcohol (e.g. alcohol prep wipes).

Cleaning common areas: Cleaning of high traffic public spaces (e.g. common spaces within the home) should follow regular cleaning and disinfecting regimes, both in terms of products used and surfaces targeted. It is recommended that items that cannot be easily cleaned (e.g., newspapers, magazines) be removed from communal living areas. Newspapers and magazines for personal use of a resident is acceptable but should not be shared.

Physical Distancing

Ways to practice physical distancing include:

- Avoid shaking hands
- When having conversations with others, observe a two (2) metre, or six (6) foot distance
- Sit at least two (2) metres apart;
- Wipe down shared surfaces, and practice frequent cleaning;
- Do not share food, plates or cutlery during dining.

Use of Masks

Masks should be used by a symptomatic individual, if available, to provide a physical barrier that may help to prevent the transmission of the virus by blocking the dispersion of large respiratory droplets propelled by coughing, sneezing and talking. A face mask should always be combined with other measures such as respiratory etiquette and hand hygiene. They can be worn by people suspected or confirmed of having COVID-19 when in close contact with other people in the home-setting or if they must leave the home-setting for medical attention.

Given the rapid increase in community spread of COVID-19 within Canada, and possible transmission from those who are pre-symptomatic or asymptomatic, universal masking for the duration of shift for

all CCF staff and any essential visitors can be implemented.

Community Care facilities are encouraged to perform an assessment to determine if universal masking is reasonable. This is based on the needs of the resident population within the facility (level of care required, age of residents and prevalence of co-morbidities).

The rationale for universal masking of CCF staff and essential visitors is to reduce the risk of transmitting COVID-19 infection from staff or visitors to vulnerable residents when symptoms of illness may not be recognized.

- When entering the CCF staff will perform hand hygiene and put on a mask
- Staff will wear mask securely over their mouth and nose and adjust the nose piece to fit snugly while mask is worn.
- When the mask becomes wet, damp or soiled (from breathing or external splash), and at the end of shift or upon leaving the facility, it must be discarded in the waste receptacle. If remaining in or returning to the facility, a new mask should be donned.
- At minimum two masks per shift will be required as mask will be removed and discarded for breaks.

Resident and Staff Screening and Management

- Staff screening must include a self-assessment for potential exposures and symptoms of COVID-19. Staff self-assessment should occur twice daily.
- If a staff member develops symptoms of COVID-19 at work they should immediately perform hand hygiene, ensure that they do not remove their mask, inform their supervisor, avoid further resident contact, leave as soon as it is safe to do so and call 1-855-354-4358 to arrange testing
- During this time, the employee will be on sick leave until test results are confirmed.
    - If the test results are negative for COVID-19 but the employee remains ill/symptomatic, the staff member will remain on sick leave.
    - If the test results are negative for COVID-19 and the employee is no longer ill/symptomatic, the employee may return to work.
- If the test results are positive for COVID-19 the employee follows the direction of Public Health and continues to self-isolate for 14 days and 2 negative swabs are reported.
- Residents should be screened for symptoms daily.
- Symptoms in elderly residents may be subtle or atypical, and staff who are screening residents should be sensitive to detection of changes from the resident's baseline physical and cognitive status.
- If a resident develops symptoms, call 811 and testing will be arranged via the Cough/Fever Clinics.
- Droplet Contact Precautions (Appendix B) are initiated immediately for all residents with suspect or confirmed COVID-19 .
- Private rooms are preferred. If not available, separation of 2 metres must be maintained between the bed space of an ill resident and all roommates with privacy curtains drawn.

- Signage indicating droplet and contact precautions is placed on the outside of resident room with suspected or confirmed COVID-19.
- If the resident was tested due to being symptomatic for COVID 19, test is negative but remains symptomatic, retesting may be done 4 to 7 days after the initial test in consultation with the CPHO.
- Staff should initiate and maintain a line listing of residents (Appendix C) with suspected or confirmed COVID-19.

Visitors

Visitors should be restricted to those deemed essential for the functioning of the facility e.g. food delivery, supplies etc. Visitors may also be permitted for compassionate reasons (e.g. end of life).

Resident Activity

Resident Admission

- Test resident on admission to the facility regardless of symptoms and if negative, again at 7 days. Testing at 7 days can be arranged by calling 811 to arrange in house testing.
- New asymptomatic resident should be in self-isolation for 14 days following admission.
- A resident who displays signs or symptoms of COVID-19 should immediately be placed on droplet/contact precautions (Appendix B) and tested.

Outbreak Management

In the context of the COVID-19 pandemic, a single laboratory-confirmed case of COVID-19 in a resident or staff member in a CCF defines an outbreak.

Implementation of Control Measures

Immediately report and discuss the suspected outbreak with the Chief Public Health Officer (CPHO) or designate.

Infection Prevention and Control

During an outbreak all outbreak control measures take priority over routine operations until the outbreak is declared over.

Facility

- Post outbreak notification sign(s) at facility entrance
- Maintain an outbreak line list (Appendix C) of cases in residents and a line list of cases in staff (nursing, food handlers, housekeeping, etc.) and forward to the CPHO daily.
- Close the facility to new admissions, readmissions, or transfers unless medically necessary.

Environmental Cleaning and Disinfection

- Ensure the disinfectant product has a Drug Identification Number (DIN) on its label and that it is effective against enveloped viruses (e.g. influenza)

- In the event that commercially prepared hospital disinfectants are not available, diluted bleach solution may be used to disinfect the environment.
- The minimum concentration of chlorine should be 5000 ppm or 0.5% (equivalent to a 1:9 dilution of 5% concentrated liquid bleach.
- All surfaces, that are considered "**frequently touched"** (e.g. telephone, bedside table, overbed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom, etc) should be cleaned and disinfected at a **minimum of twice daily and when soiled**.
- Resident care equipment (e.g., BP cuffs, electronic thermometers, oximeters, stethoscope) should be cleaned and disinfected after each use and between residents.
- **Room cleaning and disinfection** should be performed at least **once per day on all low touch surfaces** (e.g., shelves, bedside chairs, windowsills, overbed light fixtures, etc.).
- All surfaces or items, **outside of the resident room, that are touched by or in contact with staff** (e.g., computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) should be cleaned and disinfected **at least daily and when soiled**. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.

Linen, Dishes and Cutlery

- No special precautions are recommended; routine practices are used.

Waste Management

- No special precautions are recommended; routine practices are used.

Resident Care Equipment

- All reusable equipment and supplies, electronics, personal belongings, etc., should be dedicated to the use of the resident with suspect or confirmed COVID-19 infection.
- If use for other residents is necessary, the equipment and supplies should be cleaned and disinfected with a hospital disinfectant, ensuring adequate contact time before reuse. Items that cannot be appropriately cleaned and disinfected should be discarded.

Resident Placement/Cohorting

- Choose a room in the residence with a door that can be closed to separate unwell residents who have symptoms or are being tested for COVID-19 from those who are healthy for 14 days.
- If a private room is not possible and will be shared by well and unwell residents, make sure the room has good airflow (open windows as security protocols and weather permits), and that the residents can be kept 2 metres or 6 feet away from each other.
    - Separate residents sharing a room by hanging a curtain, sheet or blanket.
- Provide the residents of the room with hand sanitizer and instruct them how to use it in the room.

- If the room must be shared by more than one person who is unwell with confirmed COVID-19, these residents are not required to wear masks
- Identify a separate bathroom for the unwell person to use, if possible. If a private bathroom is not available, consider developing a schedule for use with the unwell person going last, followed by a thorough cleaning of the bathroom.

Resident transfers

- Caring-in-place should be considered if possible.
- If an admission or transfer is considered medically necessary, discuss with the CPHO.
- Notify the receiving hospital or clinic to ensure that care can be provided safely.
- Droplet and contact precautions (Appendix B) should be maintained by staff during resident transport, and the need for droplet and contact precautions should be communicated to the transferring service and receiving unit ahead of transfer.
- The resident should be provided with clean attire, be accompanied by staff, wear a mask, be instructed to perform hand hygiene (with assistance as necessary), and avoid touching surfaces or items outside of the room. Wheelchairs or transport stretchers should be cleaned and disinfected prior to exiting the resident's room.
- If a resident is transferred to an acute care facility for treatment of COVID-19 or its complications, they may return to the facility when they are medically stable.
- Residents transferred to an acute care facility who do not have COVID-19 should not generally be re-admitted back to the outbreak facility until the outbreak is declared over.

Staff allocation

- Staff should be dedicated to working in **one** CC facility during an outbreak.
- Cohort staff when possible e.g. staff working with symptomatic residents should avoid working with residents who are well.
- If dedicated staff for ill residents is not available, staff should first work with the well residents, then move on to care for ill residents.
- Staff working in a facility experiencing an outbreak should not work in facilities that do not have a COVID-19 outbreak.
- Staff who have recovered from COVID-19 may work and should be prioritized to work in facilities experiencing an outbreak.

Declaring the Outbreak Over

The outbreak may be considered over when no new cases in residents or staff are identified for at least 14 days and in consultation with the Chief Public Health Office.

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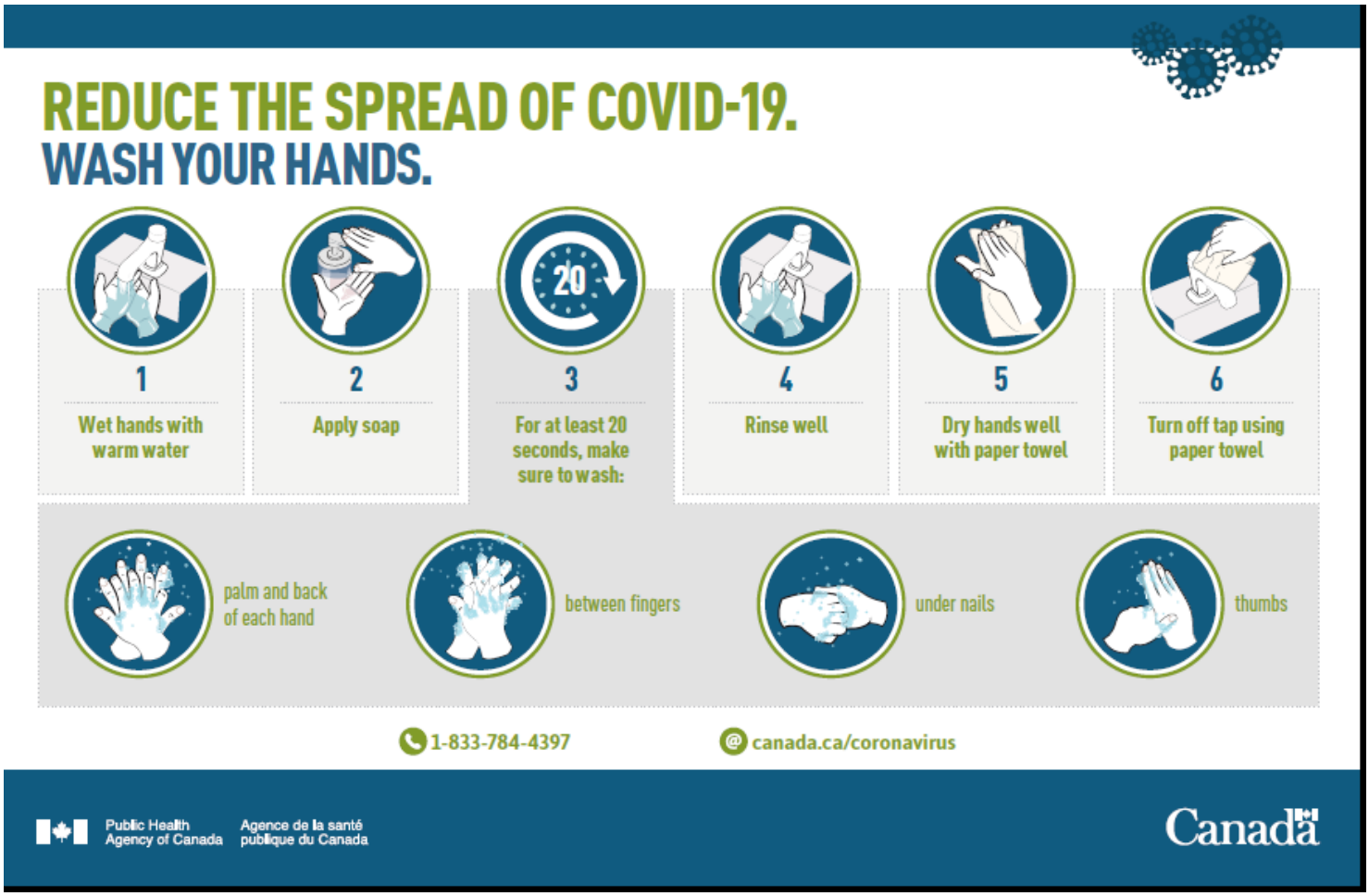
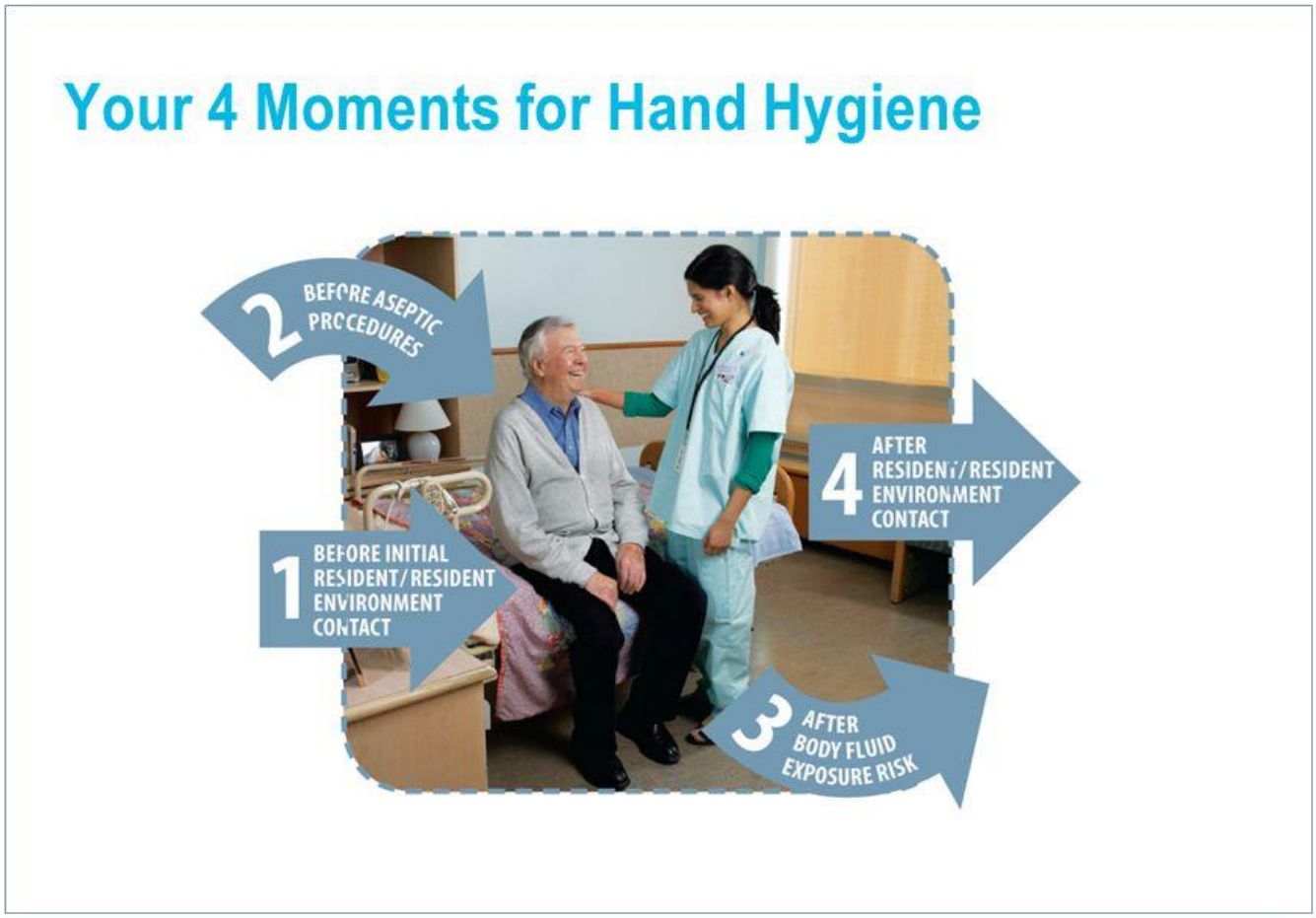
Appendix A: Hand Hygiene




Your 4 Moments for Hand Hygiene
2 BEFORE ASEPTIC PROCEDURES
1 BEFORE INITIAL RESIDENT/RESIDENT ENVIRONMENT CONTACT
4 AFTER RESIDENT/RESIDENT ENVIRONMENT CONTACT
3 AFTER BODY FLUID EXPOSURE RISK

Appendix B: Contact and Droplet Precautions

Contact and Droplet Precautions

Suspected or Confirmed Resident with Respiratory Illness (Influenza-like Illness, Influenza, COVID-19) follow Contact/ Droplet Precautions. This includes the appropriate selection and use all of the following personal protective equipment (PPE).

- Gloves
- Long-sleeved gown
- Facial protection, such as a surgical/procedure mask and eye protection/ face shield, or surgical/procedure mask with visor attachment

All PPE should be removed before leaving the patient's room and discarded into a no-touch receptacle.

Donning PPE Order

1. Perform hand hygiene
2. Don gown
3. Apply mask
4. Apply face shield or goggles
5. Put on gloves

Doffing PPE Order

1. Remove gown and gloves (can be removed together)
2. Perform hand hygiene
3. Remove face shield or goggles (do not touch the front)
4. If appropriate remove mask touching only the strings or ear loops.
5. Perform hand hygiene

Appendix C: Line List

Facility: **Date:**

RESIDENTS: Total Number of Residents:			Number of Residents ill:				
Name	**Onset Date**	**Unit**	**Symptoms**	**MRN**	**Swabbed If Yes, Date**	**Comments**
			☐ Fever[1] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
STAFF: Total Number of Staff:			**Number of Staff ill:**			
Name	**Onset Date**	**Last Date of Work**	**Symptoms**	**MRN**	**Swabbed If yes, Date**	**Comments**
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	
			☐ Fever[2] ☐ Sudden onset cough ☐ Muscle/body aches ☐ Sore Throat ☐ Headache		Date Y or N	

[1] Fever = 1) single oral temp >37.8°C 2) Repeated oral temps >37.2°C or rectal temps >37.5° or 3) Single >1.1C over baseline from any site.