



**RESOURCE
MANUAL**

MARCH 2022

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**INFECTION
PREVENTION
AND CONTROL**

**FOR COMMUNITY BASED
CONGREGATE LIVING SETTINGS**

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GLOSSARY

Additional Precautions (AP): Precautions (i.e., Contact Precautions, Droplet Precautions, and Airborne Precautions) that are necessary in addition to Routine Practices for certain pathogens or clinical presentations. These precautions are based on the method of transmission (e.g., contact, droplet, airborne).¹⁰

Blood Borne Infection: An infection transmitted through contact with infected blood or other potentially infectious body fluids.⁵

Cleaning: The physical removal of foreign material (e.g., dust, soil) and organic material (e.g., blood, secretions, excretions, microorganisms). Cleaning physically removes rather than kills microorganisms. It is accomplished with water, detergents, and mechanical action.¹⁰

Direct care: Providing hands-on care (e.g., bathing, washing, turning clients, changing clothes, continence care, dressing changes, care of open wounds/lesions, toileting).¹¹

Disinfectant: A product that is used on surfaces or medical equipment/devices which results in disinfection of the equipment/device. Disinfectants are applied only to inanimate objects. Some products combine a cleaner with a disinfectant.¹⁰

Disinfection: The inactivation of disease-producing microorganisms. Disinfection does not destroy bacterial spores. Medical equipment/devices must be cleaned thoroughly before effective disinfection can take place. See also, Disinfectant.¹⁰

Environment of the Client: The immediate space around a client that may be touched by the client and may also be touched by the health care provider when providing care. The client environment includes equipment, medical devices, furniture (e.g., bed, chair, and bedside table), telephone, privacy curtains, personal belonging (e.g., clothes, books) and the bathroom that the client uses.¹⁰

Hand Hygiene: A general term referring to any action of hand cleaning. Hand Hygiene relates to the removal of visible soil and removal or killing of microorganisms from the hands. Hand hygiene may be accomplished using soap and running water or hand sanitizing with an alcohol-based hand rub (ABHR) that is 70-90% alcohol based.¹⁰

Hand Washing: The physical removal of microorganisms from the hands using soap (plain or antimicrobial) and running water.¹⁰

High-Touch Surfaces: High-touch surfaces are those that have frequent contact with hands. Examples include doorknobs, call bells, bedrails, light switches, and wall areas around the toilet and edges of privacy curtains.¹⁰

Hospital-Grade Disinfectant: A low-level disinfectant that has a drug identification number (DIN) from Health Canada indicating its approval for use in Canadian hospitals.¹⁰

Infection: The entry and multiplication of an infectious agent in the tissues of the host. Some infections can produce symptoms others do not but can still be contagious.¹⁰

Infection Prevention and Control (IPAC): Evidence-based practices and procedures that, when applied consistently in an environment, can prevent, or reduce the risk of infection in clients, staff, and visitors.¹⁰

Infectious Agent: A microorganism, (i.e., a bacterium, fungus, parasite, virus, or prion) which is capable of invading body tissues, multiplying and causing infection.¹⁰

Low-Touch Surfaces: Surfaces that have minimal contact with hands (e.g., walls, windowsills, ceilings, and mirrors).¹⁰

Personal Protective Equipment (PPE): Clothing or equipment worn by staff for protection against hazards (e.g., gloves, mask, gown, goggles).¹⁰

Point of Care Risk Assessment (PCRA): (also known as personal risk assessment) is a dynamic risk assessment completed by a health care worker before every patient care/interaction in order to determine whether there is risk of being exposed to an infection. A PCRA will help determine the correct personal protective equipment (PPE) required to protect the health care worker in their interaction with the patient and patient environment

Routine Practices: The system of infection prevention and control practices recommended by the Public Health Agency of Canada to be used with all clients during all care to prevent and control transmission of microorganisms in community shelter settings.¹⁰

INTRODUCTION

Infection prevention and control is the key to promoting healthy people and a healthy environment. Community based congregate living setting staff and volunteers have the responsibility of maintaining a healthy **environment** for their clients. The intent of this guide is to inform and educate staff and volunteers on current recommendations for **infection prevention and control** measures, to reduce the risk of transmission of microorganisms in congregate living settings.

CHAIN OF INFECTION¹²

For an individual to get an **infection**, a process involving six elements of transmission must occur. Transmission does not take place unless all six of the elements in the chain of transmission are present. The goal of **infection prevention and control** practices is to break a link in the chain of transmission to prevent the transfer of microorganisms and therefore prevent infection.

THE SIX ELEMENTS OF THE CHAIN OF TRANSMISSION

Infectious Agent - Any microorganism that can cause infection (e.g., bacteria, viruses, parasites, fungi or prions).

Reservoir - Any place that an **infectious agent** can live and reproduce (e.g., people, food or water, soil, and animals).

Portals of Exit - The way the **infectious agent** leaves the reservoir. Can occur through the mouth and nose, GI tract excretions, blood, or drainage from wounds.

Modes of Transmission - The way the infectious agent travels. Can be direct contact from one person to another (i.e., touching), indirect contact (i.e., from one person to an object or surface and then to another person), droplets (when a person coughs or sneezes) or airborne (when extremely small particles are released into the air).

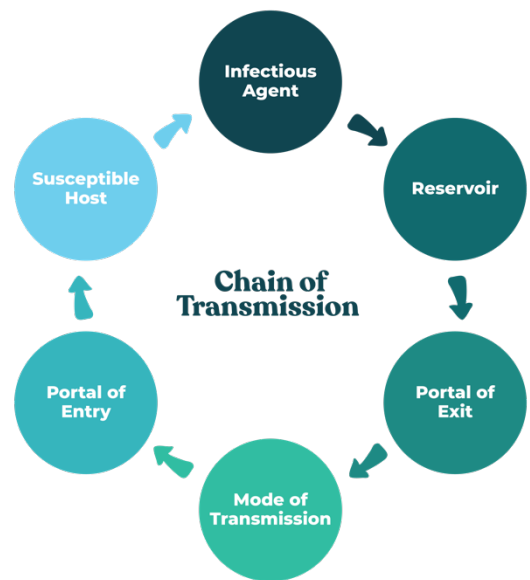
Portals of Entry - The way an infectious agent enters a susceptible host. The individual may breathe it in, touch their eyes, nose or mouth or eat or drink contaminated food or water. The infectious agent may also enter through breaks in the skin.

Susceptible Host - Any person who is at risk of developing an infection. The individual risk will depend on the infectious agent and personal factors such as age, immune system function, and vaccination history, among others.

Transmission will not occur if any of the six links are eliminated or broken through effective infection prevention and control measures.

Ways to break the chain of infection include:

- Frequent hand washing and covering coughs and sneezes
- Ensuring vaccinations are up to date
- Staying home when you are sick
- Environmental cleaning and disinfection
- Storing food properly
- Water treatment
- Disposing of waste properly



IMMUNIZATION 9, 11

One of the most effective preventive measures to protect clients and staff from acquiring communicable diseases is immunization. It is important to stay up to date on all publicly funded vaccinations.

Appropriate vaccines for susceptible congregate living site employees, volunteers and students include:

- COVID-19 (SARS-CoV-2) Vaccination
- Influenza vaccine (ideally in November/December annually)
- Measles, mumps, rubella (MMR) vaccine (two doses as a child or as an adult)
- Varicella vaccine (chickenpox) (two doses; or proof of immunity via history of chickenpox or blood test)
- Hepatitis A/B combination vaccine (two to three dose series), not publicly funded
- Meningococcal vaccine (may not be publicly funded)
- Diphtheria, Tetanus, and pertussis vaccine (one dose as an adult, then diphtheria and tetanus every 10 years)

For further information regarding immunizations contact Toronto Public Health, see [Appendix A](#).



ROUTINE PRACTICES ¹¹

Routine practices refer to infection prevention and control practices used with all clients during all care to prevent the transmission of microorganisms.

Routine practices consist of:

Point of Care Risk Assessment (PCRA)

A risk assessment must be done before each interaction with a client or their environment. This will determine which interventions are required to prevent transmission of microorganisms. The risk assessment should consider the possibility of:

- Contamination of skin or clothing by microorganisms in the client environment
- Exposure to blood, bodily fluids, secretions, excretions, tissues
- Exposures to non-intact skin
- Exposure to mucous membranes
- Exposure to contaminated equipment or surfaces

When there is a risk of transmission of infection based on the risk assessment, appropriate controls and personal protective equipment must be used to protect the staff member and client.

Hand Hygiene

Is the most important and effective infection prevention and control measure to prevent the spread of infection. Hand hygiene is to be performed with soap and water or alcohol-based hand rub before and after contact with clients or their environment, before invasive/aseptic procedures and after body fluid exposure risk.

Practice good hand hygiene:

- when your hands are visibly dirty
- after:
 - sneezing, coughing or blowing your nose
 - using washroom
 - handling garbage
 - changing diapers
 - handling raw foods
 - outdoor play
- before and after:
 - preparing and eating food
 - touching a cut or open sore
 - touching eyes, nose or mouth



Follow these steps for clean hands (see Appendix D):

1. Wet hands
2. Apply soap
3. Lather for 15 seconds. Rub between fingers, back of hands, fingertips, under nails
4. Rinse well under running water
5. Dry hands well with paper towel or hot air blower
6. Turn taps off with paper towel, if available

Hand Sanitizing

Hand sanitizers are very useful when soap and water are not available. When your hands are not visibly dirty, then a 70-90% alcohol-based hand sanitizer can be used. People who are involved in food preparation should not use hand sanitizers but instead, wash their hands with soap and water.

Follow these steps will help to kill germs in your hands:

1. Apply sanitizer (minimum 70% alcohol-based).
2. Rub hands together.
3. Work sanitizer between fingers, back of hands, fingertips, under nails.
4. Rub hands until dry.

Personal Protective Equipment (PPE)

(Donning and Doffing in [Appendix D](#)) – is used to prevent transmission of infectious agents from client to staff, staff to client, client to client and staff to staff.

PPE is used to prevent exposure by placing a barrier between the infectious source and one's mucous membranes, airways, skin and clothing.

Selection of the appropriate PPE is based on the risk assessment that dictates what is worn to break the chain of transmission.

PPE should be put on just prior to the interaction with the client.

When the interaction has ended the PPE should be removed immediately and disposed of in the appropriate receptacle. Hand hygiene must be preformed after removing PPE, including after glove use.

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE) ¹¹

Gloves

Gloves must be worn when the hands are expected to come into contact with mucous membranes, non-intact skin, tissue, blood, body fluids, secretions, excretions, or equipment and environmental surfaces contaminated with the above.

Gloves are not needed for routine activities that are limited to contact with intact skin of a client. In this case, ensure that hand hygiene is performed before and after contact with the client.

Tips for Glove Use:

- Gloves are task-specific and are to be used for one task only, then disposed of
- Select the appropriate size of gloves
- Gloves should be put on immediately before the activity for which they are indicated and removed immediately after the activity is complete, in a way that prevents contamination (see [Appendix D](#))
- Complete hand hygiene prior to putting on gloves
- Complete hand hygiene immediately after taking off gloves
- Gloves must be changed if hands have touched a contaminated body site and will then be touching a clean body site
- Do not re-use gloves
- The same pair of gloves must not be used to touch more than one client



Gowns

When it is anticipated that an activity will generate splashes or sprays of blood, body fluids, secretions or excretions, a gown must be worn.

Gowns should be cuffed, long-sleeved and offer full coverage of the front of the body from neck to mid-thigh or below.



Tips for Gown Use:

- Gowns should only be worn when providing care for clients
- The gown should be put on immediately prior to the task it is indicated for and worn properly (e.g., tied at the top and around the waist)
- Gowns must be removed immediately after task in a manner that prevents contamination (see [Appendix D](#))
- Never re-use a gown
- Do not travel between clients or environments while wearing the same gown

Masks

A mask is used in addition to eye protection to protect the mucous membranes of the mouth and nose when it is anticipated that an activity is likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or if within two metres of a client who is coughing. Clients should be encouraged to wear a mask if they are coughing to limit the spread of respiratory illness.

Tips for Using Masks:

- Masks should fit securely and cover the nose and mouth
- Masks should be substantial enough to prevent droplet penetration
- Masks must be changed if they become wet
- Do not touch a mask while wearing it
- Remove and discard mask immediately after completion of task in a way that prevents contamination (See [Appendix D](#))
- Do not allow a mask to hang around the neck
- Do not reuse masks
- Do not fold masks



Eye Protection

Eye protection is used in addition to a mask to protect the mucous membranes of the eyes when it is anticipated that an activity is likely to generate splashes or sprays of blood, body fluids, secretions, or excretions, or within two metres of a coughing client.

Eye protection includes:

- Safety glasses
- Safety goggles
- Face shields
- Visor attached to masks



Tips for Eye Protection Use:

- Personal eye wear such as prescription eyeglasses are not acceptable eye protection
- If prescription eyeglasses are needed, they must be worn underneath suitable eye protection
- Eye protection must be removed immediately and discarded after the task in which they were used, in a way that prevents contamination (See [Appendix D](#))
- If reusable eye protection is used, it should be placed in a receptacle for cleaning after removal
- Eye protection should fit securely, be comfortable and not interfere with visual acuity

CLEANING AND DISINFECTION ¹⁰

NOTE: Please discuss the cleaning and sanitizing of food preparation/handling areas with an Environmental Health Public Health Inspector (see [Appendix A: How To Reach The Toronto Public Health Unit](#)). The recommendations below do not apply to food handling/preparation areas.

A contaminated environment can play a role in the transmission of infection. In the congregate living setting, the role of environmental cleaning is important because it reduces the number and number of infectious agents that may be present and may eliminate routes of transfer of microorganisms from one person/object to another, thereby reducing the risk of infection.

An environmental risk assessment may be done to aid in determining the necessary frequency of cleaning, the level of disinfection and the number of staff required to maintain the required level of cleaning.



Things to consider when conducting an environmental risk assessment include information about the types of clients in the facility, the amount of traffic in an area, the type of activities performed in an area and the probability of being exposed to body fluids.

Clients shed microorganisms into the environment, particularly if they are coughing, sneezing or have diarrhea. Bacteria and viruses may survive for weeks or months on dry surfaces in the client's environment. In general, the client environment includes the client's individual environment (e.g., bed space, bathroom) and personal mobility devices (e.g., wheelchair, walker) and may include shared spaces such as common rooms, dining areas, central showers, and washrooms.

Some items in the client's environment have been shown to harbour organisms that can cause illness; examples are listed below. Cleaning disrupts the transmission of these microorganisms from the contaminated furniture or equipment to the client or staff. Improving cleaning practices will contribute towards controlling health care-associated infection and associated costs.

Items found to harbour microorganisms (e.g., *C.difficile*, influenza virus and others) in a congregate living setting include: beds and linens, furniture, door handles, computer keyboards, telephones, faucets, light switches, bathrooms, pens, sinks and televisions.

High-touch surfaces in the immediate vicinity of a client may be a reservoir for pathogens. The hands of clients and staff transmit these pathogens directly or indirectly. It is recommended that high-touch 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 are those that have minimal contact with hands. These surfaces can be cleaned less frequently (e.g., weekly, monthly) but cleaned sooner if visibly soiled. 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 agents with the items and surfaces to be cleaned
- Identifying when items can no longer be cleaned due to damage
-

The ease of cleaning is an important consideration in the choice of materials. This applies to medical equipment and all finishes and surfaces including materials for floors, ceilings, walls, and furnishings.

Carpeted floors are not recommended in congregate living settings. This is because carpeted floors are usually more heavily contaminated than non-carpeted floors and can be a reservoir for germs. If they are used, they should be vacuumed regularly, cleaned immediately when a spill occurs, and shampoo/steam cleaned on a regular basis. Wet carpets should be dried as soon as possible, as the risk of mold increases if carpets remain wet for 48 hours or longer. If a soiled carpet cannot be properly cleaned, it must be replaced as soon as possible. During an outbreak, carpets should not be vacuumed as there is a potential to re-circulate germs into the air from the carpet. See [Appendix E](#) for cleaning and disinfecting procedure checklists.

Cleaning

Cleaning is the removal of foreign material (e.g., dust, soil, organic material such as blood, secretions, excretions, and microorganisms) from a surface or object. Cleaning physically removes rather than kills microorganisms, reducing the organism load on a surface. It is accomplished with water, detergents, and mechanical action. The key to cleaning is the use of friction to remove microorganisms and debris. Thorough cleaning is required for any equipment/device to be disinfected, as organic material may inactivate a disinfectant. This may be accomplished through a two-step process involving a cleaner, followed by a disinfectant, but is more commonly accomplished through a one-step process using a combined cleaner/disinfectant product.

Detergents and cleaning agents remove organic material and suspend grease or oil. Equipment and surfaces must be cleaned with approved hospital-grade cleaners and disinfectants. Equipment cleaning/disinfection should be done as soon as possible after items have been used. It is important to follow the manufacturer's instructions when using cleaning agents with respect to dilution, temperature, water hardness and use. Cleaning agents should also be used according to the product's Material Safety Data Sheet (MSDS).

Disinfection

Disinfection is a process used on objects and surfaces to kill microorganisms.

Disinfectants rapidly kill or inactivate most infectious agents. Disinfectants are only to be used to disinfect and must not be used as general cleaning agents, unless combined with a cleaning agent as a cleaner-disinfectant. Skin antiseptics must never be used as environmental disinfectants.

Several factors influence the choice of disinfectant; contact Toronto Public Health (see [Appendix A](#)) who can discuss the various categories of disinfectants to help guide your decision.

When using a disinfectant:

- It is most important that the item or surface be free of visible soil
- A hospital-grade low-level disinfectant may be used for equipment that only touches intact skin (e.g., hydraulic lift, crutches)
- It is important that the disinfectant be used according to the manufacturer's instructions for dilution and contact time
- Minimize the contamination levels of the disinfectant solution and equipment used for disinfecting (e.g., ensure proper dilution of the disinfectant, change the disinfectant solution frequently, and do not dip a soiled cloth into the disinfectant solution).
- PPE should be worn appropriate to the products used
- There should be a quality monitoring system in place to ensure the efficacy of the disinfectant over time

PPE for Cleaning and Disinfection

Staff who clean should wear PPE:

- For protection from microorganisms
- For protection from chemicals used in cleaning
- To prevent transmission of microorganisms from one client environment to another

Note: Prolonged use of gloves is not recommended because of both the increased risk of irritant contact dermatitis from sweat and moisture within the glove as well as breakdown of the glove material itself and risk of tears. Inappropriate glove use, such as going from room to room, or bed space to bed space, in care areas with the same pair of gloves, facilitates the spread of microorganisms.

- Gloves must be removed immediately after the activity for which they were used, and if disposable, discarded.
- Gloves are to be used as an additional measure, not a substitute for hand hygiene.
- Do not wash or re-use disposable gloves.
- Change or remove gloves after contact with a client environment and before contact with another client environment.
- Perform hand hygiene after removing gloves.

Administration's Role in Cleaning and Disinfection

Congregate living sites must ensure that:

- PPE is sufficient and accessible for all staff for [Routine Practices](#) and **Additional Precautions** and for personal protection from chemicals used in cleaning
-
- WHMIS training regarding appropriate handling of biohazardous material is provided, if applicable
-
- Individualized training is provided on the correct use, application and removal of PPE

Congregate living sites must have policies and procedures that ensure that:

- Cleaning is a continuous event in the shelter
- Cleaning procedures incorporate the principles of infection prevention and control (i.e., use of PPE)
- Cleaning standards, frequency and accountability are clearly defined (i.e., who cleans, what do they clean, and when do they clean it)
- Cleaning schedules ensure that no area or item is missed from routine cleaning
- Statutory requirements are met in relation to the safe disposal of clinical waste (if applicable), the safe handling of linen, food hygiene and pest control

There may be a need for additional or enhanced cleaning of a shelter during an outbreak, in order to contain the spread of the microorganism causing the outbreak. Additional cleaning in an outbreak generally depends on the microorganism causing the outbreak and further direction will be provided when the outbreak is declared.

See [Appendix E](#) for cleaning and disinfecting procedure checklists.

Refer to the Provincial Infectious Diseases Advisory Committee document [Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings](#) (April 2018) for more information on developing policies and procedures for cleaning and disinfection.

EXPOSURE TO BLOOD AND BODY FLUIDS ⁵

A blood borne infection is an infection transmitted through contact with infected blood or other potentially infectious body fluids.

The most common blood borne pathogens are Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

Exposure to blood borne pathogens may occur in the following circumstances:

- Needle stick injury
- Contact with blood or body fluids with non- intact skin or mucous membranes
- Injuries involving sharp objects that may be contaminated with blood or body fluids
- Human bites
- Injuries exposing blood that are a result of physical assaults
- Needle sharing
- Sexual contact involving blood

All persons with significant exposure should seek immediate care.

To be considered a significant exposure, potentially infected bodily fluid must come into contact with another person in one of the following ways:

- Percutaneous injury: needle stick or puncture or cut with a sharp object
- Contact with mucous membranes: splash to eyes, nose, or mouth
- Contact with non-intact skin: contact with skin that is chapped or scratched revealing blood or other potentially infectious body fluids
- Bites that break the skin or result in blood exposure to either person involved

If exposed to blood borne pathogen:

- Remove clothing contaminated with bodily fluids
- Allow the wound to bleed freely (forced bleeding and wound incision are not recommended)
- Wash the injured area well with soap and water
- If the eyes, nose, or mouth are involved, flush well with large amounts of water
- Seek immediate medical attention at the closest emergency department, walk-in clinic, or family physician's office!

SHARPS SAFETY 1, 12

Sharps are items that can cut or puncture the skin such as knives, broken glass, razor blades and needles. Sharps may be contaminated with infectious materials. If the skin is punctured with a contaminated sharp, infection can occur.

Needles are used by a variety of people, for a variety of purposes, including for medical reasons and for non-medical injection drug use. The distribution of sterile needles, as well as encouragement, education, and facilitation of proper needle disposal are key elements of evidence-based recommendations for public health and harm reduction programs, which have been shown to reduce drug-related harms¹.

Additionally, facilitating proper sharps disposal also falls outside of public health and harm reduction programs, as part of occupational safety and general maintenance of City buildings, parks, streets, and other locations. Worker safety is an important issue related to proper needle disposal.

It is important for congregate living sites to have policies and procedures in place for the safe handling of sharps, disposal of sharps and sharps injury prevention including follow-up for exposure to blood borne infections.

Sharps containers should have the following features:

- Be rigid to avoid puncturing of walls by needles
- Not have removable lids and be tamper resistant so that it is difficult to remove contents from the container
- Be yellow and labelled with a universal biohazard symbol
- Be able to withstand the weight of the waste without breaking, leaking, tearing, or cracking
- Be labelled with a fill line (boxes should not be filled more than 2/3 as this increases the chances of box malfunction, and therefore risk of injury); and
- Large boxes that are to be placed outdoors on horizontal surfaces should not be able to topple over

Things to remember about sharps:

- Keep sharps disposal containers in areas where sharps litter is present
- Siting a sharps disposal container needs to take into consideration the people who will use the box to dispose of needles, and the people who will empty and maintain the container.
 - Place it below shoulder level (if mounted on the wall)
- Never recap sharps
- Do not dispose of sharps in the regular garbage
- Discard needles in a sharps disposal container immediately after use
- Never use bare hands to clean up sharps, wear gloves and use tongs/pliers/tweezers
- Do not fill a sharps container past ¾ full

OUTBREAKS ^{7, 8}

Due to the close living and sleeping quarters, congregate living settings provide a favourable environment for illness to spread.

An outbreak is suspected when there are a greater than expected number of ill clients (cases), with similar symptoms, in the same location, within a specific timeframe.

As per the Health Protection and Promotion Act O. Reg. 558/91: Specification of Communicable Diseases and O. Reg. 559/91: Specification of Reportable Diseases, outbreaks of gastroenteritis and respiratory infections that occur in institutions are reportable to the local public health unit.

Toronto Public Health works with health care professionals to manage outbreaks and apply effective public health strategies to prevent the transmission of infectious diseases. Complete the Initial Outbreak Notification Form found at <https://s.tphsurvey.chkmt.com/?e=254916&h=7A6EB3571D2CDDC&l=en> (Appendix A: How to Reach The Toronto Public Health Unit)

In general, when two or more clients are sick with the same symptoms, within 48 hours of each other, the health unit should be contacted to discuss whether an outbreak is occurring.

Gastroenteritis

Gastroenteritis refers to illness that affects the gastrointestinal tract (i.e., stomach, bowels) resulting in symptoms such as nausea, vomiting and/or diarrhea. Many viruses, bacteria and parasites cause this type of illness in people. A case of gastroenteritis is a client or staff with two or more episodes of vomiting and/or diarrhea (takes the form of its container) in a 24- hour period that cannot be explained by other reasons (e.g., laxatives).

Respiratory Infection

Respiratory infection refers to illness that affects the respiratory tract (i.e., lungs, breathing passages) resulting in symptoms such as cough, congestion, sore throat, and runny nose. Many bacteria and viruses cause this type of illness in people. A case is a client or staff with two or more respiratory symptoms (e.g., runny nose, cough, fever or abnormal temperature, sore throat, or hoarseness, etc.) that are new or cannot be explained by other reasons (e.g., allergies).

Surveillance

Surveillance means assessing clients and staff daily for signs and symptoms of illness. The key to managing the spread of communicable diseases is maintaining a high degree of awareness for illness in clients and staff and the consistent use of [Routine Practices](#).

If there is an increase or an unexpected amount of illness in the shelter and you require guidance or have further questions, see [Appendix A](#) for Toronto Public Health Unit Contact Information.

OUTBREAK MANAGEMENT AND THE ROLE OF THE HEALTH UNIT

Prevention and Preparedness

Advise homes on outbreak prevention (including hierarchy of controls) and preparedness for managing positive cases, contacts and outbreaks, in conjunction with advice provided through the Ministry of Health (MOH), the MCCSS, MMAH, and any other relevant ministry.

Case and Contact Management/Outbreak Management

Receive and investigate reports of suspected or confirmed cases and contacts in accordance with the *Health Protection and Promotion Act, 1990* (HPPA), Public Health Management of Cases and Contacts of COVID-19 in Ontario and the COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance.

- Will obtain further information on the clients in the congregate living setting (e.g., how many are ill, what their symptoms are, when they started, and how many are living in the setting) in order to confirm whether an outbreak is occurring.
- Enter cases, contacts, and outbreaks in the provincial surveillance system, in accordance with data entry guidance provided by Public Health Ontario
- Determine if an outbreak exists and declare an outbreak.
- Provide guidance and recommendations to the home on outbreak control measures in conjunction with advice provided by MOH, as well as MCCSS and/or other ministries as relevant.
- Make recommendations on who to test, facilitate a coordinated approach to testing, in collaboration with Ontario Health, including provision of an investigation or outbreak number (if applicable).
- Host and coordinate outbreak meetings with the home, PHO, Ontario Health, Infection Prevention and Control (IPAC) Hubs, etc.
- Issue orders by the medical officer of health or their designate under the HPPA, if necessary.
- Declare the outbreak over.

Coordination and Communication

- In the event that a case or contact resides in a Public Health Unit (PHU) that is different than that of the congregate living setting, discussions between the respective PHUs should take place to coordinate contact follow-up and delineate roles and responsibilities.
- The PHU of the home is typically the lead PHU for home follow-up.
- Request support from the Ministry of Health's Emergency Operations Centre (MEOC) if coordination between multiple PHUs is required for outbreak management.
- Notify the MEOC (EOCOperations.moh@ontario.ca) of:
 - Potential for significant media coverage or if media releases are planned by the PHU and/or CLS.

- Any orders issued by the PHU's medical officer of health or their designate to the CLS and share a copy.
- Engage and/or communicate with relevant partners, stakeholders and ministries, as necessary.

Refer to [Appendix C: Reporting an Outbreak](#) for further information.

Role of the Congregate Living Setting (CLS)

- Review and consider any guidance provided by the province (i.e., MOH, MLTSD, among others relevant ministries) and/or their local PHU.
- Be aware of their legal obligations and duties under relevant legislation, including the *Occupational Health and Safety Act*, (OHSA), the ROA, and their regulations, as applicable, and ensure compliance. **Note:** All employers under OHSA have a duty to take every precaution reasonable in the circumstances for the protection of a worker. This includes protecting workers from infectious disease. For more information, see [Occupational Health and Safety section below](#).
- As best practice, ensure adequate supplies, including appropriate PPE, are maintained.
- Accurate records of staff attendance, all visitors, and client information. should be maintained. This information should be available to be accessed and shared with the local PHU in a timely manner (within 24 hours) for investigations and communication upon request. Visitor logs should include, at minimum, the name of the visitor, reason for entering the CLS, location(s) and/or client(s) visited, and dates/times of the visit to facilitate contact follow-up if needed.
 - Records of staff attendance and visitor logs, as well as their up-to-date contact information, should be kept for the last 30 days.
 - Facilitate access to staff lists of those not directly employed by the CLS (e.g., third party/temporary agency workers) and provide to the PHU.
- Name(s) and contact information of a designated point of contact for use during and/or after business hours, to ensure timely investigation and follow up of cases, contacts, and outbreaks should be provided to the PHU.
- As much as operationally feasible, collect data on staff and client vaccination rates for COVID-19 and influenza consistently through a process (that includes written consent), and make this available to PHUs to inform their investigation. Any data should be collected, retained and disposed of in a manner that respects privacy, including complying with the *Personal Health Information and Protection Act, 2004* (PHIPA) where applicable.
 - **Note:** where sector-specific policy is issued by a relevant ministry, CLSs should follow those directions for collecting and reporting data on COVID-19 immunization rates.
- In addition to any duty to report a suspected or confirmed case of COVID-19 under the HPPA and any other legal reporting requirements, as applicable, administrators of all CLSs are encouraged to contact their local PHU if a resident, staff, or essential visitor has or may have COVID-19 to facilitate timely contact tracing and outbreak management within the setting. It is important to indicate the type of care setting to the local PHU as they are tracking cases within CLSs.
 - CLSs should also notify other ministries and/or organizations that provide oversight, as appropriate (e.g., MMAH funded settings should notify their municipal Service Manager or District Social Services Administration Board).

- Follow the directions of the local PHU if any staff or clients have COVID-19, are exposed to someone with COVID-19, or if there is a suspect or confirmed outbreak in the CLS.
- Coordinate with the local PHU and other stakeholders as appropriate on the implementation of outbreak measures in the setting.
- Communicate proactively with the CLS staff, visitors, clients, and clients' families/support networks about COVID-19 outbreak measures and about how ill individuals, cases, contacts, and outbreaks will be handled.

Influenza

Influenza is a respiratory illness caused primarily by the influenza A and B viruses.

While most people recover in 7-10 days, severe illness can occur. Some groups are at greater risk of influenza-related complications including:

- children under 5 years and adults over 65 years of age
- people who are pregnant
- residents of congregate living settings
- children and adults living with chronic health conditions such as diabetes, cancer, obesity

Symptoms

Influenza symptoms typically include sudden onset of:

- high fever
- cough
- muscle aches and pains

Other common symptoms include:

- headache
- chills or feeling feverish
- fatigue
- loss of appetite
- sore throat
- runny/stuff nose

Transmission

Influenza is primarily transmitted by droplets and spread through coughing or sneezing. It may also be transmitted through direct or indirect contact with infected respiratory secretions.

The incubation period of influenza is usually 2 days, but can range from 1 to 4 days. Adults may be able to spread influenza to others from 1 day before symptoms start to approximately 5 days after.

Children and people with weakened immune systems may be infectious for longer.

Vaccination and Treatment

Getting vaccinated against influenza each fall is the best way to help prevent infection. Influenza (flu) viruses are constantly changing which is why a new flu vaccine is needed each flu season. Most people with influenza will become only mildly ill and do not need medical care or antiviral medication from their primary care provider.

TUBERCULOSIS (TB) ^{3, 4}

TB is a contagious disease caused by TB germs. TB usually attacks the lungs but can affect any part of the body. TB has been around for centuries.

Spread/Transmission

Close, prolonged, or regular contact with someone who is sick with TB disease is needed to spread the disease. It spreads from person to person through the air only when someone who is sick with active TB disease in the lungs coughs, talks, sings or sneezes.

TB is not highly contagious. TB is not spread by sharing utensils, plates, cups, clothing, bed linen, furniture, toilets, by shaking hands or by touching surfaces that have been touched by someone with TB.

People whose TB is in another part of the body (for example, glands/lymph nodes) cannot spread the TB germs to others.

Latent Tuberculosis Infection or LTBI:

Is an infection where *Mycobacterium tuberculosis* bacteria is found in the lungs. Exposure occurs when a person with active TB of the lung's coughs, sneezes, speaks, or sings and another person breathes in the bacteria and becomes infected. Generally, a healthy immune system stops the bacteria from growing and they remain "dormant" or "sleeping;" when this happens the infected person is not sick, has no symptoms, and is not able to transmit the bacteria to others. This is called latent tuberculosis infection (LTBI). Someone with LTBI is at risk of developing active tuberculosis (TB). Certain people are at an increased risk of developing active TB such as those who: are HIV positive, have lung scars that show on an x-ray, use alcohol or injection drugs, have diabetes or certain types of cancer, take medications that affect the immune system and those who are underweight.

A person with latent TB **infection:**

- Usually, has a positive TB skin test result
- Has a normal chest x-ray
- Has TB bacteria in his/her body that are inactive
- Does not feel sick
- Cannot spread TB bacteria to others
- Can get treatment for latent TB infection to prevent TB disease

Active Mycobacterium Tuberculosis Disease:

Occurs when the TB bacteria become active and one's immune system cannot stop them from growing and multiplying.

It is usually found in the lungs, but the bacteria can attack any part of the body such as the kidney, spine, or brain. Someone with active TB disease is usually sick and may spread TB germs to anyone they spend time with daily.



Signs and symptoms of active TB infection:

- New or worsening cough that lasts for more than 3 weeks or keeps getting worse
- Feelings of tiredness or weakness
- Unexplained weight loss
- Fever
- Chills
- Night sweats
- Others (based on where the TB germs are in the body)

Testing for LTBI and Active TB:

- Physical exam by a health care provider
- Tuberculin skin test (TST)- to determine if one has been exposed to the TB germs
- A chest x-ray may be ordered, and sputum samples may be collected

REPORTING REQUIREMENTS FOR TB AND OTHER COMMUNICABLE DISEASES ⁶

Timely reporting of communicable diseases, including TB, is essential for their control. If you suspect that a client may be displaying signs and symptoms of TB or a different communicable disease, please recommend that they seek medical attention. Certain diseases, called Diseases of Public Health Significance, are to be reported to the Medical Officer of Health (as per Ontario Regulation 135/18 and amendments under the Health Protection and Promotion Act, R.S.O. c.H.7).

You can contact the Toronto Public Health Unit if you suspect or have confirmed that a client is infected with a Disease of Public Health Significance.

The Diseases of Public Health Significance Notification form can be found on the Toronto Public Health website at www.toronto.ca/community-people/health-wellness-care/. See [Appendix A](#) for the Toronto Public Health unit contact information. For a complete list of diseases reportable to the health unit see [Appendix B](#).

Appendix A



HOW TO REACH THE
TORONTO PUBLIC
HEALTH UNIT

APPENDIX A - HOW TO REACH THE TORONTO PUBLIC HEALTH UNIT

Address: 277 Victoria Street, 5th Floor
Toronto, ON M5B 1W2

Telephone: 416-338-7600, option 1

Email: publichealth@toronto.ca

Website: <https://www.toronto.ca/community-people/health-wellness-care/>

Staff Directory: https://www.toronto.ca/wp-content/uploads/2017/12/9537-public_health.pdf

Appendix **B**

**DISEASES OF PUBLIC
HEALTH SIGNIFICANCE
(DOPHS)⁶**

APPENDIX B – DISEASES OF PUBLIC HEALTH SIGNIFICANCE (DOPHS) ⁶

For information about any of the diseases of public health significance below, please contact the Communicable Disease Surveillance Unit at 416-392-7411 or After hours 3-1-1

COMMUNICABLE DISEASE REPORTING

CONTACT INFORMATION:

Toronto Public Health - Communicable Disease Surveillance Unit

277 Victoria Street, 10th Floor, Toronto, ON M5B 1W2

Phone: 416-392-7411 -- Fax: 416-392-0047

After hours: 3-1-1 or 416-392-CITY (2489) for callers from outside of Toronto

Timely reporting of communicable diseases is essential for their control.

If you suspect or have laboratory confirmation of any of the following specified diseases of public health significance or their etiologic agents (as per Ontario Reg 135/18 and amendments under the Health Protection and Promotion Act) please report them to the local Medical Officer of Health.

Diseases marked * should be reported **immediately** to the Medical Officer of Health by telephone (24 hours a day, 7 days a week) or fax (Mon-Fri, 8:30 am – 4:30 pm only). Other diseases can be reported the next working day by fax, phone, or mail.

Acquired Immunodeficiency Syndrome (AIDS)	Food poisoning, all causes	* Meningococcal disease, invasive
Acute Flaccid Paralysis	* Gastroenteritis, outbreaks in institutions and public hospitals	Mumps
Amebiasis	Giardiasis (symptomatic cases only)	Ophthalmia neonatorum
* Anthrax	Gonorrhoea	Paralytic Shellfish Poisoning
Blastomycosis	* Group A Streptococcal disease, invasive	Paratyphoid Fever
* Botulism	Group B Streptococcal disease, neonatal	Pertussis (Whooping Cough)
* Brucellosis	* Haemophilus influenzae disease, all types, invasive	* Plague
Campylobacter enteritis	* Hantavirus Pulmonary Syndrome	Pneumococcal disease, invasive
Carbapenemase-producing Enterobacteriaceae (CPE)	* Hemorrhagic fevers, including:	* Poliomyelitis, acute
Chancroid	1. *Ebola virus disease	Psittacosis/Ornithosis
Chickenpox (Varicella)	2. *Marburg virus disease	* Q Fever
Chlamydia trachomatis infections	3. *Other viral causes	* Rabies
* Cholera	* Hepatitis, viral	* Respiratory infection outbreaks in institutions and public hospitals
* Clostridium difficile associated disease (CDAD) outbreaks in public hospitals	1. *Hepatitis A	* Rubella
* Coronavirus, novel including SARS, MERS and COVID-19	2. Hepatitis B	Rubella, congenital syndrome
* Creutzfeldt-Jakob Disease, all types	3. Hepatitis C	Salmonellosis
Cryptosporidiosis	Influenza	* Shigellosis
Cyclosporiasis	* Lassa Fever	* Smallpox
* Diphtheria	Legionellosis	Syphilis
Echinococcus multilocularis infection	Leprosy	Tetanus
Encephalitis, including:	Listeriosis	Trichinosis
1. Primary, viral	Lyme disease	Tuberculosis
2. Post-infectious	* Measles	Tularemia
3. Vaccine-related	* Meningitis, acute	Typhoid Fever
4. Subacute sclerosing panencephalitis	1.* Bacterial	* Verotoxin-producing E. coli infection, including Haemolytic Uraemic Syndrome (HUS)
5. Unspecified	2. Viral	West Nile Virus illness
	3. Other	Yersiniosis

Appendix

**REPORTING AN
OUTBREAK^{7, 8}**


APPENDIX C – REPORTING AN OUTBREAK

7, 8







Reporting an Outbreak?

Contact your Toronto Public Health Long-term Care and Retirement Homes Congregate Team (LRCT) Liaison

To report a new suspected or confirmed COVID-19, Respiratory and/or Enteric outbreak in a Long-Term Care or Retirement Home complete the  [Initial Outbreak Notification e-Form](#).



During Business Hours (Mon-Fri, 9AM- 5PM)	Weekends/ Statutory Holidays (7 days a week 9AM- 5PM)	After Hours 5PM – 9AM (7 days a week)
 Call and/or email your LRCT Liaison immediately.	Email  LRCT@toronto.ca inbox.	 Call 311 (or 416 392 2489) and ask to speak to the Communicable Disease Manager.
Note: To report an individual case of a Disease of Public Health Significance to TPH, please telephone and/or fax (fax #: 416 392 0047) in the Communicable Disease Reporting Form found here  www.toronto.ca/ReportACommunicableDisease		

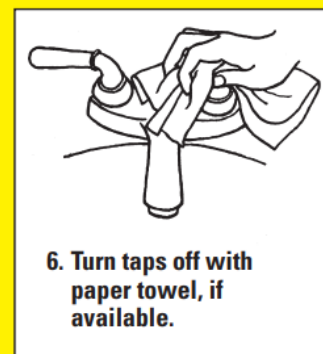
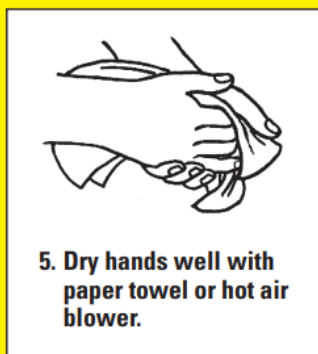
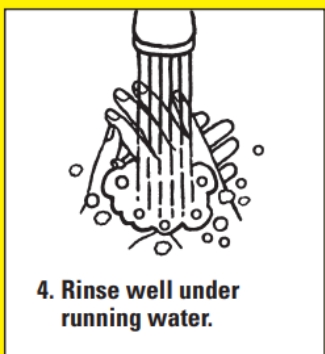
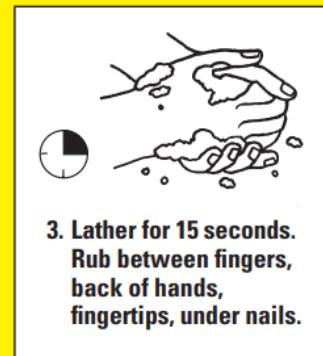
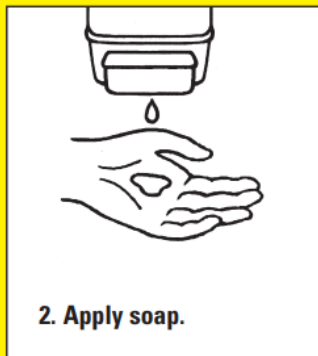
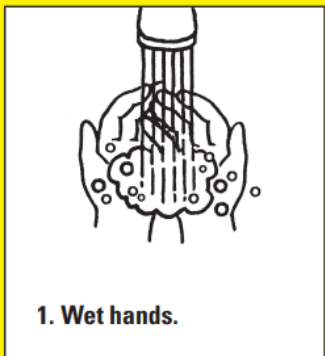
Appendix **D**



HEALTH HYGIENE
BEST PRACTICES ¹¹

APPENDIX D – HEALTH HYGIENE BEST PRACTICES ¹¹

Hand Washing



Stop the Spread of Germs

Always Wash Your Hands

After you:

- Sneeze, cough or blow your nose
- Use the washroom or change diapers
- Handle garbage
- Play outdoors

Before and after you:

- Prepare or eat food
- Touch a cut or open sore

PH1306/0011

Hand Sanitizing



1. Apply sanitizer (minimum 70% alcohol-based).



2. Rub hands together.



3. Work sanitizer between fingers, back of hands, fingertips, under nails.



4. Rub hands until dry.

Stop the Spread of Germs

Always Sanitize Your Hands

After you:

- Sneeze, cough or blow your nose
- Use the washroom or change diapers
- Handle garbage
- Play outdoors

Before and after you:

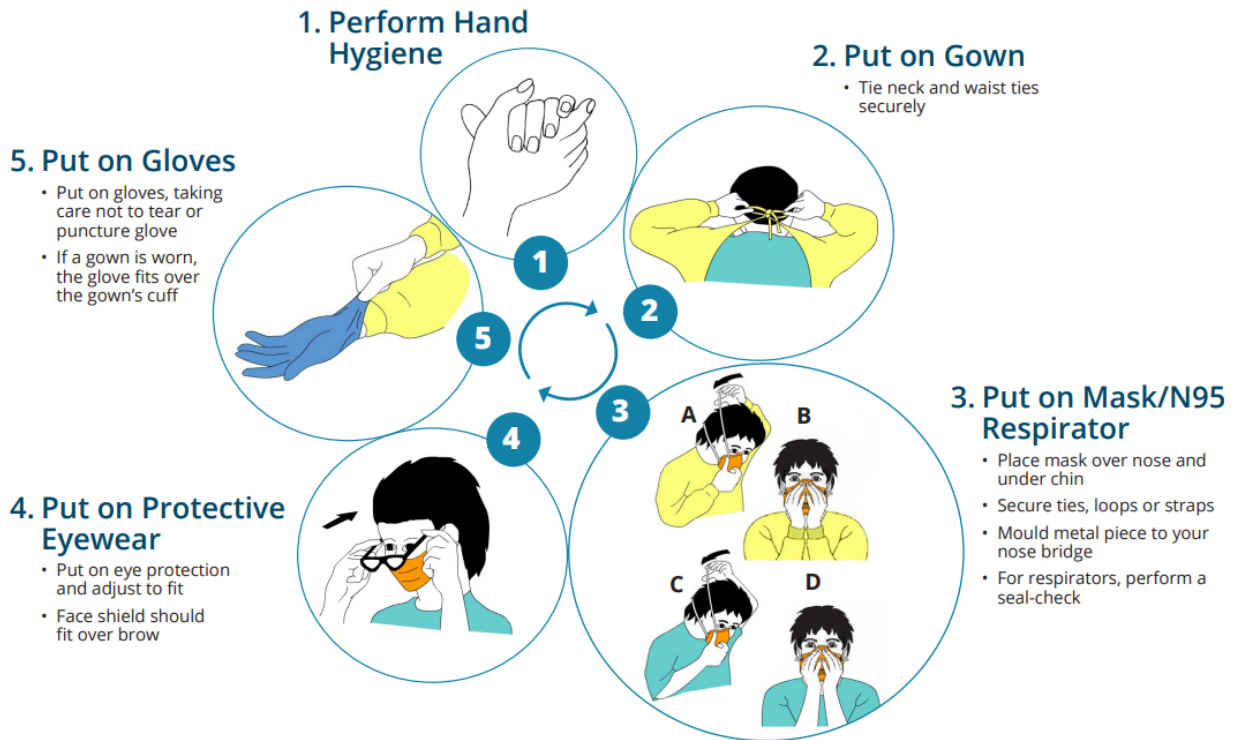
- Prepare or eat food
- Touch a cut or open sore

If hands are visibly dirty use soap and water

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Recommended Steps: Putting On Personal Protective Equipment (PPE)



For more information, please contact Public Health Ontario's Infection Prevention and Control Department at ipac@oahpp.ca or visit www.publichealthontario.ca.

How to Put On Personal Protective Equipment

1 PERFORM HAND HYGIENE



2 PUT ON GOWN



3 PUT ON MASK OR
N95 RESPIRATOR



4 PUT ON EYE PROTECTION



5 PUT ON GLOVES



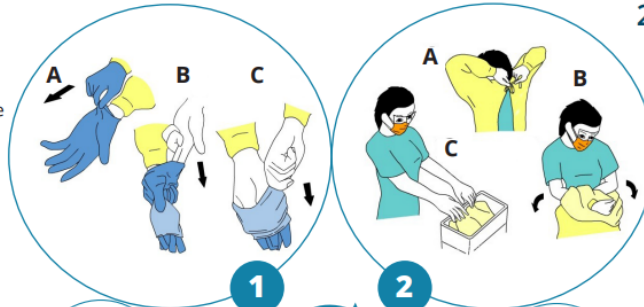
For more information, visit publichealthontario.ca

Ontario 

Recommended Steps: Taking Off Personal Protective Equipment (PPE)

1. Remove Gloves

- Remove gloves using a glove-to-glove / skin-to-skin technique
- Grasp outside edge near the wrist and peel away, rolling the glove inside-out
- Reach under the second glove and peel away
- Discard immediately into waste receptacle



2. Remove Gown

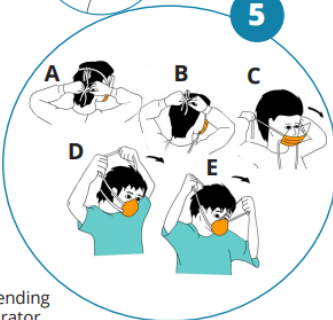
- Remove gown in a manner that prevents contamination of clothing or skin
- Starting with waist ties, then neck ties, pull the gown forward from the neck ties and roll it so that the contaminated outside of the gown is to the inside. Roll off the arms into a bundle, then discarded immediately in a manner that minimizes air disturbance.



6. Perform Hand Hygiene

5. Remove Mask/ N95 Respirator

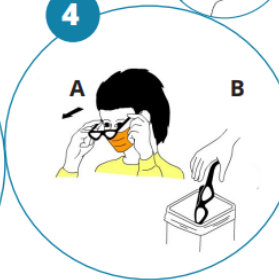
- Ties/ear loops/straps are considered 'clean' and may be touched with hands
- The front of the mask/respirator is considered to be contaminated
- Untie bottom tie then top tie, or grasp straps or ear loops
- Pull forward off the head, bending forward to allow mask/respirator to fall away from the face
- Discard immediately into waste receptacle



3. Perform Hand Hygiene

4. Remove Eye Protection

- Arms of goggles and headband of face shields are considered to be 'clean' and may be touched with the hands
- The front of goggles/face shield is considered to be contaminated
- Remove eye protection by handling ear loops, sides or back only
- Discard into waste receptacle or into appropriate container to be sent for reprocessing
- Personally-owned eyewear may be cleaned by the individual after each use



This is an excerpt from Routine Practices and Additional Precautions In All Health Care Settings (Appendix L) and was reformatted for ease of use.

How to Remove Personal Protective Equipment

1

REMOVE GLOVES



2

REMOVE GOWN



3

PERFORM HAND HYGIENE



4

REMOVE EYE PROTECTION



5

REMOVE MASK OR
N95 RESPIRATOR



6

PERFORM HAND HYGIENE



Cover Your Cough



1. Cover your mouth and nose when you cough, sneeze or blow your nose.



2. Put used tissue in the garbage.



3. If you don't have a tissue, cough or sneeze into your sleeve, not in your hands.



4. Clean your hands with soap and water or hand sanitizer (minimum 70% alcohol-based).

Stop the Spread of Germs

Always Cover Your Cough

- Covering your cough or sneeze can stop the spread of germs
- If you don't have a tissue, cough or sneeze into your sleeve
- Keep your distance (more than 2 metres/6 feet) from people who are coughing or sneezing

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Appendix **E**



**CLEANING AND
DISINFECTION
IN CONGREGATE
LIVING SITES^{2, 10}**

APPENDIX E – CLEANING AND DISINFECTION IN CONGREGATE LIVING SITES^{2, 10}

CLEANING OF BLOOD AND BODY FLUIDS CHECKLIST ^{2,10}

1. Assemble materials required for dealing with the spill. Material needed:
 - Disposable paper towels
 - PPE (gloves, gown, facial protection, mask, or face shield)
 - Regular waster receptacle or biomedical waste receptacle for larger spills
 - Hospital-grade disinfectant (e.g., ethyl or isopropyl alcohol disinfectants, improved hydrogen peroxide, quaternary ammonium compounds, or bleach). It is important that hospital-grade disinfectants be used according to the manufacturer's instructions for dilution and contact time and according to the product's safety data sheet.
2. Inspect the area around the spill for splatters and splashes that may have occurred outside of the main spill area
3. Restrict the activity around the spill until area has been cleaned, disinfected, and dried
4. Perform hand hygiene and put on gloves. If there is a possibility of splashing, wear a gown and facial protection (mask, eye protection or face shield)
5. Confine and contain the spill
6. Wipe up any blood or body fluid spills immediately using disposable paper towels
7. Dispose of materials by placing them into a regular waste receptacle except if soiled materials are so wet with body fluid that fluid can be squeezed out, in this case dispose of materials in a biomedical waste container
8. Clean/disinfect the entire spill area with a hospital-grade disinfectant and allow it to stand for the amount of time recommended by the manufacturer
9. Wipe up the area again using disposable towels and discard into regular waste
10. Take care to avoid splashing or generating aerosols during the clean up
11. Remove PPE in the correct order and perform hand hygiene

ROOM CLEANING AND DISINFECTING CHECKLIST ^{2,10}

1. Gather cleaning materials and supplies
2. Perform hand hygiene and put on gloves
3. Remove dirty linen:
 - Strip the bed and pillows
 - Roll sheets carefully to prevent aerosols from getting into the air
 - Discard the linen into the soiled linen bag
 - Inspect bedside curtains and window treatments and if visibly soiled, remove these as well following the same process
4. Remove gloves and perform hand hygiene
5. Apply clean gloves
6. When beginning the cleaning procedure, use a fresh cloth saturated with cleaning solution/disinfectant
7. Clean with only one cloth at a time. When finished with one area, set cloth aside for laundering, and use a fresh cloth to continue. If a bucket is used, do not “double dip” the cloth.
8. If there is more than one resident bed space in the room, use fresh cloths for each, and complete the cleaning in each bed space before moving on to the next.
9. When cleaning, always work in a systematic fashion from the least soiled areas (low-touch) to the most soiled areas (high-touch) and from high surfaces to low surfaces, proceed with the following steps:
 - Clean doors, door handles, push plate and touched areas of the door frame
 - Check walls for visible soiling and clean if required
 - Clean light switches and thermostats
 - Clean wall-mounted items such as the alcohol-based hand rub dispenser
 - Check and replace any sharps containers, check sharps container and change when sharps reach the fill line; clean the sides and bottom of the sharps container, but do not dust the top of the sharps container
 - Check and remove fingerprints and soil from glass door panels, mirrors, and windows with glass cleaner
 - Clean all furnishings and horizontal surfaces in the room. This includes chairs, windowsill, television, telephone, night table and other tables or desks, support railings, ledges and shelves. Lift items to clean the tables, and pay particular attention to high-touch surfaces
10. Clean the top and sides of the mattress, and then turn the mattress over and clean the underside.
 - Make sure you check for cracks or holes in the mattress, and have the mattress replaced as required. You must also clean the pillows and inspect for pests.

11. Clean inside and outside of any closets
12. Remove gloves and clean hands with ABHR; if hands are visibly soiled, wash with soap and water
13. Do not leave room wearing soiled gloves
14. Once you've allowed the mattress and pillows to dry, you can remake the bed accordingly.
15. Replenish supplies as required
16. Dispose of soiled linens, cleaning materials and waste
17. Clean floors (see floor cleaning procedure)

WASHROOM CLEANING AND DISINFECTING CHECKLIST ^{2,10}

1. Gather cleaning materials
2. Prepare cleaning and disinfectant solution according to the manufacturer's instructions. If using separate cleaning and disinfecting solutions follow steps 1-9 with cleaning solution and then repeat steps 4-9 with disinfectant solution
3. Perform hand hygiene and put on gloves
4. Change cloths when they are no longer saturated with disinfectant or cleaning solutions and after cleaning heavily soiled areas
5. It is important to clean from clean to dirty areas:
 - Remove soiled linen and place it in linen bag
 - Remove debris from the floor and place it in the waste receptacle
 - Dry and wet spots with paper towel and place in the waste receptacle
 - Remove waste from the room, handling plastic bags from the top
 - Be alert for sharps. Using a mechanical device to pick these up and place them in the sharps container, and report the incident to the supervisor when cleaning is complete
6. Remove gloves and perform hand hygiene.
7. Put on fresh gloves
8. Working from the least soiled areas to the most soiled areas and from high surfaces to low surfaces, use the following procedures:
 - a. Clean the door, door handles, push plate and touched areas of the door frame
 - b. Check walls for visible soiling and clean if required
 - c. Clean light switches, wall attachments and mirrors
 - d. Clean all dispensers, frames, cabinets, and shelves
 - e. Clean railings, ledges, shelves, and pipes
 - f. Clean shower/tub faucets, walls, and railings – scrub as required to remove soap scum
 - g. Clean entire toilet including handles and underside of flush rim
9. Remove gloves and perform hand hygiene
10. Replenish supplies in washroom (e.g., paper towel, soap, toilet paper, garbage bag, sanitizer)
11. Clean floor (see floor cleaning checklist)

FLOOR CLEANING CHECKLIST ^{2,10}

Perform hand hygiene and put on gloves

Step 1: Use a dry mop, start at the back of the room and work towards the door:

- Remove any gross soilage and debris from the floor
- Once you start dust mopping, do not lift dust mop off the floor until you have completed task. Use a swivel motion of the frame and wrist to change direction
- Move furniture aside and replace after dust mopping
- Dispose of debris, being careful not to stir up dust
- Remove the mop head for laundering
- Remove gloves and perform hand hygiene

Step 2: Wet mop – if using a wet loop mop and bucket:

- Prepare cleaning solution as per manufacturer's instruction. Be sure to change cleaning solution throughout cleaning to maintain appropriate concentration of the solution
- Place 'wet floor' caution sign outside of room or area being mopped
- Perform hand hygiene and put on gloves
- Dip mop in cleaning solution and wring out
- Start at the back of the room and work towards the door (e.g., clean around baseboards and corners first)
- In open areas, use a figure eight stroke, overlapping each stroke; turn mop head over every five or six strokes
- Mop a three-metre, or 9ft x 9ft area, then rinse and wring out mop
- Repeat until entire floor is mopped
- Change the mop head when heavily soiled and at the end of the day for laundering.
- Empty and rinse the bucket

Step 2: Wet mop – if using a microfibre mop:

- Prepare cleaning solution as per manufacturer's instructions. Be sure to change cleaning solution throughout cleaning to maintain appropriate concentration of the solution
- Place 'wet floor' caution sign outside of room or area being mopped
- Place microfiber pads to soak in the cleaning solution
- Perform hand hygiene and put on gloves
- Remove a soaked microfiber pad, wring it out and attach to mop head
- Start at the back of the room and work towards the door (e.g., clean around baseboards and corners first)
- In open areas, use a figure eight stroke, overlapping each stroke; turn mop head over every five or six strokes
- Mop a three-metre, or 9ft x 9ft area, then rinse and wring out mop
- Repeat until entire floor is mopped
- Replace microfiber pad when soiled and use a fresh microfiber pad for each room
- Remove gloves and perform hand hygiene

Appendix **F**



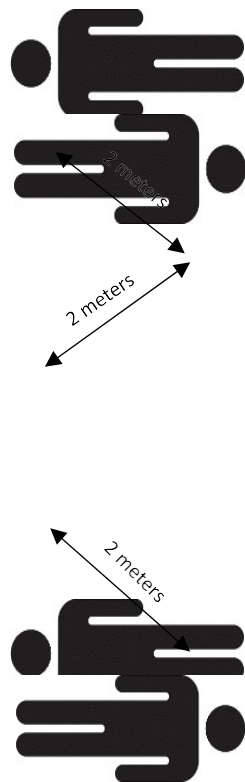
BED SPACING

APPENDIX F – BED SPACING ^{12, 13}

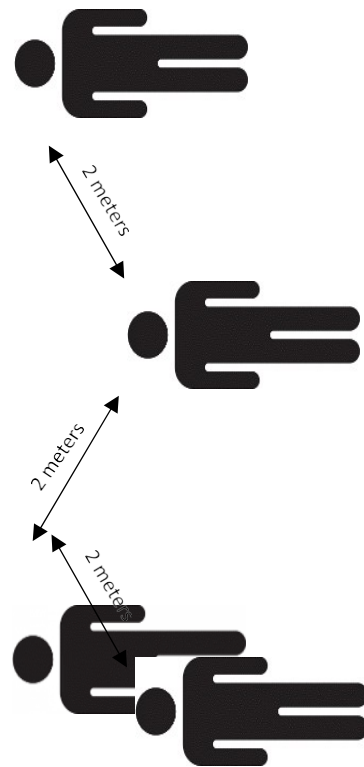
As germs in respiratory droplets (e.g., coughing and sneezing) can spread up to two meters, aim for beds to be spaced so that there is a separation of two meters between clients, to decrease the risk of spreading germs.

Examples of ways a two-meter bed spacing can be achieved are through a head-to-toe bed placement as shown in example A, or staggering beds as shown in example B.

Example A

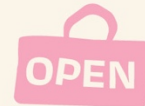
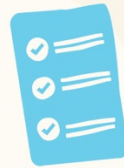


Example B





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