L’CHAIM RETIREMENT HOME- POLICY FOR INFECTION PREVENTION AND CONTROL

POLICY FOR

INFECTION CONTROL & PREVENTION

(PSW Students)

L'CHAIM RETIREMENT HOME- POLICY FOR INFECTION PREVENTION AND CONTROL

Infection Prevention and Control

In the event of an outbreak or illnesses, L'chaim Retirement Home will endeavour to maintain life as "normal" for residents to the extent that we are able. We will request and require the participation of members and staff in the infection prevention and control measures required within the Residence in order to protect the health and safety of all persons.

Members and their visitors can reduce the incidence of infectious disease outbreaks by doing the following:

- Use hand sanitizer upon entering and exiting from the home. Report any flu like symptoms. It is best not to enter the home if you are experiencing flu like symptoms.
- It is highly recommended to receive the flu shot for those members who are able to get it as well as staff.
- Proper hand washing is imperative for stopping the spread o

At L'chaim Retirement Home, we have an infection prevention and control program in place. Our program includes the following prevention and control measures:

- The Licensee will consult on an ongoing basis and not less than once a year with the local medical officer of health or designate about identifying and addressing health care issues in the Residence in order to reduce the incidence of infectious disease outbreaks in the home.
- The Licensee will keep a written record of its consultation with the local medical officer of health or designate that will include a record of when the consultation took place, what was discussed and any recommendations that the local medical officer of health or designate made.
- The Licensee shall ensure that a written surveillance protocol is established in consultation with the local medical officer of health or designate in order to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness.
- The licensee of a retirement home shall ensure that,
    - if an infectious disease outbreak occurs in the Residence, the outbreak is

reported to the local medical officer of health or designate and the Licensee defers to the officer or designate, as the case may be, for assistance and consultation as appropriate;
    - if there is an increase in the number of symptomatic residents in the Residence, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted; and
    - processes for meeting the above requirements are established and the processes are recorded in writing.
- The Licensee will ensure that each resident and the resident's substitute decision-makers (if any), are given information about how to reduce the incidence of infectious disease, including the need for and method of maintaining proper hand hygiene and the need for and process of reporting infectious illness.
- The Licensee will ensure that waterless, alcohol-based hand sanitizer or another form of hand sanitation that provides equivalent protection against infectious disease transmission is available for use by residents and staff in communal resident areas and in staff work areas.
- The licensee of a retirement home shall ensure that, each resident, each member of the staff of the Residence and each volunteer receive information about the advantages of an annual influenza vaccination and where the vaccination is available;
    - each resident is screened for tuberculosis within 14 days of commencing residency in the Residence, unless the resident has been screened not more than 90 days before commencing residency and the documented results of the screening are available to the Licensee;
    - each member of the staff has been screened for tuberculosis and all other infectious diseases that are appropriate in accordance with evidence-based practices or, if there are no such practices, in accordance with prevailing practices; and
    - staff screening for each of the infectious diseases has been done using procedures that accord with evidence-based practices or, if there are no such practices, with prevailing practices.
- The Licensee shall ensure that each staff member who works in the Residence receives training on how to reduce the incidence of infectious disease transmission, including,
    - the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items; and
- the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness

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1.0 Introduction

Infectious disease outbreaks occur throughout the year but are more common from the fall to early spring.

Outbreak prevention, preparation/implementation of control measures and early detection are vital to effective outbreak management.

Experience with new emerging or re-emerging infectious diseases has resulted in a greater emphasis on infection control practices, characterized by high standards of practice that reflect an enhanced awareness of the potential for transmission of infectious diseases.

1.1 Purpose of the Guide

The purpose of this procedure is to assist in preventing, detecting and managing outbreaks of infections which arise from the transmission of common viral and bacterial pathogens.

This policy will:

• help prevent outbreaks of respiratory disease

• help develop surveillance systems to monitor respiratory illness and identify outbreaks early

• help in investigating and managing outbreaks of respiratory infections.

Investigation and management include:

 identifying symptoms to form a case definition for the specific outbreak

 consulting promptly with health care professionals when there is suspicion of an outbreak

 outlining outbreak control measures

Prevention

Immunization

Influenza and pneumococcal vaccination of a member is helpful in reducing the impact of these vaccine-preventable diseases. It is highly recommended to both members and staff to receive annual influenza vaccination, unless contraindicated.

2.1.2 Education

Ongoing education of staff, volunteers, residents and residents' families about infection and outbreak prevention and related policies must be part of the infection control program.

Topics to include in education programs for all staff and residents are:

• hand hygiene

• appropriate disinfection of equipment (any equipment that is shared between residents must be disinfected after each use)

• standard environmental cleaning

• persons experiencing symptoms of infection should not be working/visiting the home

• immunization

• influenza outbreak management and exclusion policies of the home.
Residents, visitors and volunteers shall be provided with similar information.

2.2 Surveillance

2.2.1 Definition and Goal
i. Background
Surveillance is an essential component of any effective infection control program. An important goal of surveillance is to ensure early identification of a potential outbreak or an outbreak in its early stages so that control measures can be instituted as soon as possible.
Surveillance should be done for members, staff, and all those entering the Centre.
All persons carrying on activities within the home must self screen based on the signage posted and exclude themselves from entering the home when they have respiratory symptoms (i.e., new cough, new shortness of breath, fever)
• hand washing facilities and/or hand hygiene products are to be made available throughout the home for use by all persons entering the home
• screening tools and policies are to be posted, and followed by all entering the Centre.
i. Upper respiratory tract illness (includes common cold, pharyngitis)
The member must have least 2 of the following (new) symptoms:
• runny nose or sneezing
• stuffy nose (i.e. congestion)
• sore throat or hoarseness or difficulty swallowing
• dry cough
• swollen or tender glands in the neck
• fever/abnormal temperature for the resident may be present, but is not required.
For suspected influenza outbreaks you may also consider adding the following symptoms: tiredness (malaise), muscle aches (myalgia), loss of appetite, headache, chills.
ii. Pneumonia
All of the following criteria must be met:
• interpretation of a chest x-ray as pneumonia, probable pneumonia, or presence of infiltrate
• the member must have at least two of the signs and symptoms described under other lower respiratory tract infection (see below)
• other noninfectious causes of symptoms, in particular congestive heart failure, must be ruled out.
iii. Gastroenteritis (stomach flu)

The main symptoms are watery diarrhea and vomiting. You might also have stomach pain, cramping, fever, nausea, and a headache. Watch for signs of dehydration, such as dry skin and a dry mouth, feeling lightheaded, and being really thirsty

3.0 Outbreak Detection and Management

Even a relatively small respiratory outbreak in an institution is disruptive. Early recognition of situations signaling suspected outbreaks and swift action are essential for effective management.

Step 1. Assess the Potential or Confirmed Outbreak

Ensure that the member or staff that is ill is not present at the Centre and if it is recognized that they are ill while at the Centre, remove them from other members.

Step 2. Implement General Infection Control Measures

Control measures are to be implemented as soon as an outbreak is suspected. All staff shall be notified quickly of the outbreak, supplies (i.e. gloves, masks, etc.) shall be made available as necessary and the following measures instituted:

• reinforce the need for good hand hygiene before and after providing care to residents. Hands shall be washed after any close contact with any resident including handling used tissues and assisting in feeding. Alcohol based hand sanitizers are as effective as soap and water when hands are not visibly soiled.

• use barrier precautions, (i.e. gloves and masks) when providing direct personal care to ill members. Masks and gloves shall be removed, discarded and hands washed/disinfected upon exiting the room and/or prior to providing care to other members. Reinforce the importance of hand hygiene following removal of mask, eye protection, and gloves. Handwashing/hand hygiene after removing gloves and masks prevents contamination of hands with virus from used gloves and masks.

Step 3 Declare an Outbreak

• any further progression of the "potential outbreak" situation (additional cases or laboratory confirmations) will confirm an outbreak

Step 4 Notify Appropriate Individuals Associated with the Centre of the Outbreak

In addition to notifying the local Medical Officer of Health or designate about the outbreak (see step 3), notification may include some or all of the following individuals as appropriate for the home:

• staff members

• community volunteers (family members/ caregivers)
• attending physician
• registered nurses in the extended class (nurse practitioners)
The Outbreak Management Team Meeting should:

1. Review the line listing information to confirm an outbreak exists and ensures that all members of the team have a common understanding of the situation.

2. Develop a working case definition for the outbreak. A case definition is the criteria that will be used throughout the outbreak to consider a resident or staff member as outbreak associated case. The case definition developed for residents may be different from that developed for staff. Residents who meet this case definition will be considered a case regardless of the results of laboratory testing unless another diagnosis is confirmed.

3. Review the control measures necessary to prevent the outbreak from spreading. See Section 4.0 for Respiratory Outbreak Control Measures. Confirm the ICP or designate of the home is responsible for ensuring that agreed upon control measures are in place and enforced. Control measures may differ for different organisms and may need to be modified on an ongoing basis.

4. Appropriate signs and their placement should be confirmed

5. For influenza outbreaks, confirm the use of anti-viral medications for treatment of cases and/or prophylaxis of well residents and non-immunized staff.

6. For influenza outbreaks, confirm the implementation of the exclusion policy, review and implement the staffing contingency plan.

7. Determine if additional influenza immunization clinics are required for non immunized staff, and if so, how they will be organized.

9. Develop a process for resolving conflicts about use of personal protective equipment.

10. Identify any additional persons/institutions that require notification of the outbreak:
• Prepare internal communications for resident, family and staff groups. Determine if education sessions are required for staff members and confirm who will conduct them.

11. Confirm who will be responsible for the ongoing monitoring of the outbreak in both

residents and staff members (see Step 8).

12. Confirm how and when daily communications will take place between the home and the health unit. Ensure that contact telephone numbers are available for both the health unit and home at all times.

Step 5 Monitor the Outbreak on an Ongoing Basis
Monitoring of the outbreak must include ongoing surveillance to identify new cases and update the status of ill residents and staff. The ICP, or designate of the home will update the line listing with new information and communicate this to the health unit contact person as previously arranged. The review of the updated information should examine the issues of ongoing transmission, and the effectiveness of control measures and prophylaxis. Changes in the outbreak control measures may be indicated from the review of the data. Some control measures may be lifted as the outbreak comes under control or alternatively other measures may be added if the
outbreak is not being controlled successfully. Additional laboratory testing may be indicated as well. If new cases continue to be identified, prophylaxis failure or a new organism causing infections must be considered.
Elements of ongoing surveillance should include all of the following in the updating of line listing:
Resident Surveillance
• addition of new cases with all appropriate information (see Step 1, Resident Line Listing Information)
• identification of residents who have recovered
• updating of status of ill residents including notation of issues such as worsening symptoms, clinical and/or x-ray diagnosis of pneumonia
• adverse reaction to any prescribed antiviral prophylactic medication, or discontinuation of antiviral prophylactic medication
• transfers to acute care hospitals
• deaths
Staff Surveillance
• addition of new staff cases including all appropriate information (see Step 1, Staff Line Listing Information)
• identification of staff who have recovered and confirmation with the health unit of return to work date
Step 9 Declare that the Outbreak is Over
The length of time from the onset of symptoms of the last case until the outbreak is declared over can vary and is dependent on whether the last case was a resident or staff. Prior to declaring an outbreak over, the home must not have experienced any new cases of infection (resident or staff) which meet the case definition for the
period of time as defined by the OMT. *As a general rule, viral respiratory*

outbreaks can be declared over if no new cases have occurred in 8 days from the onset of symptoms of the last resident case

The rationale for this definition is, if the outbreak were continuing, given active surveillance, new cases would have been identified within 8 days, since 8 days is the outer limit of the period of communicability of influenza (5 days) plus one incubation period (3 days). Note that if symptoms in the last resident case resolve sooner than 5 days, or if the last case is a staff member who should stay at home during the period of communicability, the time until the outbreak is declared over
can be shortened accordingly. Since large LTCHs tend to have some sporadic influenza or respiratory infection cases in non-outbreak situations, the Outbreak Management Team (OMT) may need to attempt to differentiate between these sporadic cases and outbreak-associated cases in identifying the last outbreak related resident case.

Based on practicality, the *"8 days from the onset of symptoms of the last case"* rule in closing outbreaks could also be applied to outbreaks caused by other respiratory pathogens, with relatively short incubation periods, such as influenza. Another common way to decide when to declare an outbreak over is to use two
incubation periods for the disease. This is the approach taken with SARS.

The OMT may make decisions about ongoing surveillance needs after declaring the outbreak over. Included are the following:

• maintenance of general infection control measures as outlined in Step 2
• monitoring the status of ill residents, updating the line listing and communicating with the health unit representative
• notation of any deaths that occurred, including whether they had been a case, and informing the health unit representative
• notation of any spread amongst staff.

Once the outbreak has been declared over, all individuals notified of the outbreak at the beginning of the investigation are to be notified that the outbreak is over. Refer to Steps 5 and 6 for a listing of individuals to be notified of the end of the outbreak.

Step 10 Complete the Outbreak Investigation File

The outbreak file shall be reviewed to ensure that it contains the following:

• copies of laboratory and other results
• copies of all minutes and other communications
• any other documentation specific to the investigation and management of the outbreak.

Completion of the Final Report of an Institutional Respiratory Outbreak is to be done jointly by the home and the health unit. For a confirmed influenza outbreak the health unit will submit the completed report to the Ministry of Health and Long- Term Care within three weeks after the outbreak has been declared over. Copies of all documents related to the outbreak are to be kept on file by the Infection Control staff at the home.

Step 6 Review the Outbreak

Arrange a meeting with health unit staff to review the course and management of the outbreak. The purpose of this meeting is to review what was handled well and what could be improved for future outbreaks. Provide the report to the infection control committee and a copy to be kept by the home administration.

4.1.2 Hand Hygiene

• hand hygiene is the most important measure in preventing the spread of infection.
• avoid touching one's face and mucous membranes (including eyes) with hands.
• hand hygiene should be performed:
-before direct contact with a resident
-after any direct contact with a resident and before contact with the next resident
-before performing invasive procedures
-after contact with blood, body fluids, secretions and excretions
-after contact with items known or considered likely to be contaminated with blood, body fluids, secretions and excretions, including respiratory secretions (e.g. oxygen tubing, masks used tissues and other items handled by the resident)
-immediately after removing gloves and other personal protective equipment
-between certain procedures on the same resident where soiling of hands is likely, to avoid cross-contamination of body sites
-before preparing, handling, serving or eating food and before feeding a resident.
• waterless alcohol antiseptic hand rinses are as effective as handwashing if hands are not visibly soiled. If there is visible soiling, hands must be washed with soap and running water before using hand rinses. If soap and running water are not available, cleanse hands first with detergent-containing towelettes to remove visible soil, and then use alcohol hand rinse.
• ideally, one should not wash one's hands in a resident's washroom. If a resident's washroom is used, care must be taken to avoid hand contamination from the environment. Using an alcohol hand rinse after handwashing in this circumstance is recommended.
• residents, staff, and volunteers should be instructed in proper hand hygiene.
Care of hand hygiene in residents is necessary at all times and especially during high risk seasons. Hands should be washed or sanitized frequently but especially after using the bathroom, and before meals.

4.1.3 Gloves

• gloves are recommended when providing care involving direct contact with an ill resident
• gloves should be used as an additional measure, not as a substitute for hand hygiene
• gloves should be put on before entering and removed prior to leaving the resident's room or dedicated bed space
• gloves should fit the wearer to prevent cross contamination through contact
• gloves should be changed between dirty and cleaner procedures on the same resident, e.g ., after open suctioning of a tracheostomy, and remainder of care
• hands must be washed immediately after removing gloves

• when a gown is worn, the cuff of the gloves must cover the cuffs of the gown
• single-use gloves should not be reused or washed

4.1.4 Masks

• whenever the term mask is used in this document, the term refers to **fluid resistant surgical masks,** unless explicitly stated otherwise
• masks are recommended when providing care involving direct contact with ill residents
• for the care of a resident with respiratory illness, put a surgical mask on the resident, if tolerated, whenever the resident is not in his/her room (e.g. transfer to hospital)
• masks should be changed if they become wet, or contaminated by secretions
• staff wearing masks must remove their mask before caring for another resident, and when leaving the residents dedicated space/room
• masks should be handled only by the strings/ ties, to prevent self contamination
• masks should be changed according to the manufacturer's recommendations
• hands should be washed after mask removal
• during treatment of confirmed or suspected airborne diseases such as TB, fit tested N95 masks are recommended.

Health Canada guidelines "Infection Control Precautions for Respiratory Infections Transmitted by Large Droplet and Contact: Infection Control Guidance in a Non-Outbreak Setting, When an Individual Presents to a Health Care Institution With a Respiratory Infection" (December 17, 2003) designed to prevent the transmission of respiratory infections recommend the use of fluid resistant surgical masks.

4.1.5 Eye Protection

• eye protection includes the use of safety glasses, goggles, and face shields. It does not include personal eye glasses
• eye protection should be worn where there is a potential for splattering or spraying of blood, body fluids, secretions or excretions, including cough producing aerosol generating procedures, while providing direct resident care
• safety glasses, goggles and face shields should be removed carefully to prevent selfcontamination
• if re-used, eye protection should be cleaned in a manner that will not lead to contamination. The safety glasses, goggles, or face shields should be cleaned between uses according to the manufacturer's recommendations using a minimum of a low level disinfectant
• to prevent self-contamination, health care workers should not touch their eyes during care of a resident with a respiratory illness
• hands should be washed after removal of eye protection.

4.2 Control Measures for Residents

4.2.1 Restriction of Cases to Their Room

Restrict cases (ill residents) to their room until 5 days after the onset of acute illness or until symptoms have completely resolved (whichever is shorter). For some pathogens the period of

communicability may be longer than 5 days, but for practical reasons, this could be applied to outbreaks caused by respiratory viruses other than influenza. Restriction of ill residents to their room is recommended as long as it does not cause the resident undue stress or agitation and can be done without applying restraints.

4.2.3 Admissions and Re-admissions

i. New Admissions

Admissions of new residents to the affected unit during the outbreak is generally not permitted. If required, this measure may be altered as the outbreak comes under control. Changes in this outbreak control measure should be made in consultation with the health unit. See 4.2.3.iii for specific considerations.

ii. Re-admission of Cases

The re-admission of residents who met the case definition is permitted provided appropriate accommodation and care can be provided.

iii. Re-admission of Non-cases

The re-admission of residents who have not been line listed in the outbreak (i.e. are not known cases) is generally not permitted during an outbreak. If required, this measure may be altered as the outbreak comes under control. Changes in this outbreak control measure will be made in consultation with the health unit. Factors to assess if readmission of non-cases is being considered include:

- the outbreak is under control
- the resident's attending physician has agreed to the re-admission based on a review of the current health status of the resident in hospital
- adequate staff are available at the Long-Term care home to care for the readmitted resident
- if the outbreak is due to influenza, the resident is protected from influenza by vaccination and/or an anti-viral drug
- appropriate accommodation is available for the returning resident
- the patient/resident or their substitute decision-maker has given informed consent for the return.

Note: A resident's bed will be kept for up to 21 days while he/she receives treatment in an acute care facility, or 45 days for psychiatric leave. In the event that a resident's hospital or psychiatric stay will exceed the maximum allowable days due to an outbreak situation in the home, the MOHLTC should be notified that the period for the time the resident may remain away from the home will need to be extended.

3 Control Measures for Staff and Volunteers

4.3.1 Reporting of Respiratory Illness

Staff and volunteers with any respiratory illness should not enter the LTCH, but should report any respiratory illness to their supervisor who shall report to the employee health nurse or the ICP.

4.3.2 Exclusion of Staff, Students, and Volunteers

Staff, students, or volunteers with any respiratory symptoms are to be excluded from work for 5 days from the onset of symptoms of a respiratory illness or until symptoms have resolved, whichever is shorter.
For a confirmed influenza outbreak, ill staff, students, or volunteers taking antiviral medication for treatment (not prophylaxis) shall be excluded from work for 5 days from onset of symptoms or until symptoms have resolved, whichever is shorter.
4.3.3 Working at Other Facilities
During non-influenza outbreaks, staff, students, and volunteers should be advised not to work at any other facility. During an influenza outbreak, immunized staff have no restrictions on their ability to work at other facilities, provided the individual changes their uniform between facilities. However, non-immunized staff not receiving prophylactic therapy must wait one incubation period (**3 days**) from the last day that they worked at the outbreak facility/unit prior to working in a non-outbreak facility, to ensure they are not incubating influenza. Staff, students, and volunteers experiencing respiratory symptoms or fever should not work in any health care setting.
4.4 Control Measures for Visitors (including family) and Communal Activities
4.4.1 Notification of Visitors
The institution shall post outbreak notification signs at all entrances to the home indicating the institution is in an outbreak. Visitors shall be advised of the potential risk of acquiring illness within the home, and the re-introduction of illness into the home, and of the visiting restrictions as indicated below. Family members of ill residents shall be contacted and advised of the illness in their relative. Where possible, the home may wish to keep a telephone list of frequent visitors. These individuals may be contacted and advised of the outbreak.
4.4.2 Visitor Restrictions
Ill visitors shall not be permitted in the home. Visitors should be encouraged to postpone visits wherever possible. Visitors who choose to visit during an outbreak shall be required:
• to wash hands on arrival and just before leaving the resident's room
• to visit only one resident and exit the home immediately after the visit
• visitors should wear personal protective equipment as per Section 4.1.
Complete closure of visitation is not recommended, as it may cause emotional hardship to both the residents and the relatives, especially if they traveled from a distance. Visitation restrictions shall take into consideration whether or not the visitor/family member has been immunized or has taken prophylaxis. Visitation restrictions should be discussed by the OMT.
4.4.4. Communal and Other Activities
Visitation by outside groups, e.g. entertainers, meetings, community groups, etc., shall not be permitted. Also, visitation of multiple residents shall be restricted.
Onsite adult and childcare programs may continue provided there is no interaction between LTCH residents who are ill and participants of the program.
4.5 Cleaning
4.5.1 Environmental Cleaning

• procedures should be established for assigning responsibility and accountability for routine cleaning of all environmental surfaces including furniture (e.g. bed rails and overbed table) and non-critical resident care items (e.g. call bell)
• disinfection methods should be reviewed
• frequent cleaning of environmental surfaces and non-critical patient care items using hospital approved detergent-disinfectant is recommended
• components of an effective cleaning process include a sufficient quantity of detergent-disinfectant in the correct concentration applied with a clean cloth. It is important to comply with contact time on manufacturer's label and workplace safety requirements
• all horizontal and frequently touched surfaces should be cleaned daily and more often when soiled
• routine practices should be applied in the handling of soiled linen
• routine practices should be applied to handling clinical waste. Double bagging of waste is not required. Disposable dishes and cutlery are not required.

4.5.2. Resident Care Equipment

• remind staff, students and volunteers of the recommendations for cleaning, disinfecting and sterilizing patient care equipment in "Hand Washing, Cleaning, Disinfection and Sterilization in Health Care", 1998 (Health Canada).
• disposable equipment should be used whenever possible
• soiled patient care equipment should be handled in a manner that prevents exposure of skin and mucous membranes and contamination of clothing or the environment
• equipment should be cleaned and disinfected prior to use and between residents.

4.6 Influenza Immunization

Offer the Influenza Vaccine

During influenza outbreaks, influenza vaccine should be offered to all unvaccinated residents, staff members, visitors and volunteers. It takes approximately two weeks for the vaccine to become effective. The home or health unit will make arrangements for influenza vaccine to be delivered to the home. Staff, volunteers, and visitors may also be directed to their family physicians for immunization. Influenza vaccine is provided free to all Ontario residents over the age of six months.

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IPAC (Infection Prevention & Control) Expectations for PSW Students During a Covid Outbreak

For the safety of our home, residents, students, and staff, it is imperative to practice ALL IPAC safety measures during your shift. Camara audits will take place to ensure all safety measures are being practiced.

Please remember the residents are "clean" and the staff or students who have access to grocery stores, family life, public transit are exposed to "dirty". It is your duty to keep our residents safe from COVID by following all IPAC guidelines. Do not bring the "dirty" to the "clean" resident.

Here is a quick list of IPAC protocols:

- Masks must be worn all the time. Masks can be removed on your break time when eating and if you need to drink. Anytime you remove your mask it must be placed upside-down on a clean paper towel. Please demonstrate to the PSWs how this should be done.
- Hand sanitize for 15 seconds after touching you mask (putting on, off or adjusting)
- DO NOT PULL YOUR MASK TO YOUR CHIN. A proper removal using the straps around the ears and placing the mask on a clean paper towel is the correct way.
- Shields must be worn when entering resident rooms. Once you are less than 2 meters way from a resident, you must wear a shield.
- Anytime you touch you your shield, you must hand sanitize for 15 seconds. Consider your shield "dirty"
- Hand sanitizing is probably one of the most important aspects of infection control and will be closely monitored to ensure all PSWs are hand washing correctly.
- It is your duty to monitor the PSWs to ensure proper hand sanitization.
- When you transition from one room to the hallway you must sanitize.
- When you transition from the hallway into a room you must hand sanitize before you take a pair of gloves. Gloves should be worn on clean hands.
- When you transition from one area of the home to another i.e from the elevator to the main floor, you must hand sanitize.
- After each resident care, remove your gloves INSIDE the room. DO NOT walk out of a resident room with gloves on. You must hand sanitize before you come out of the room.
- Donn your isolation gown with clean hands. Donning should be done before entering the room.
- Doffing must be done correctly (refer to doffing instructions) inside the room. After doffing sanitize your hands before opening the door to come outside the room.
- The Nurse on shift will monitor all PSWs on the floor to ensure they are following infection control protocols.

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- The nurse on shift will have a discussion to go over the IPAC rules before the start of EVERY shift. Encourage the PSWs to ask questions and DO live examples to make sure they understand i.e show them a live example of how to hand sanitize for 15 seconds.
- The nurse on shift will make sure PSWs understand that if they touch their mask (for comfort, and itch, adjustment..) they ,must hand sanitize!
- Using the Oxivir spray, sanitize all high touch surfaces multiples time during your shift such as doorknobs and rails.
- Completely sanitize the chair each person was sitting on at the end of your shift.
- Weekly IPAC audit is required. The nurse will use the IPAC Audit Tool

Please view the following links for steps to Proper Hygiene and Putting on Protective Equipment

Public Health Ontario:
Recommended Steps: Putting on Personal Protective Equipment (PPE)

Videos:
Putting on Full Personal Protective Equipment
Taking off Full Personal Protective Equipment
Taking off Mask and Eye Protection