

AT A GLANCE

Prevention and Management of COVID-19 in Long-Term Care and Retirement Homes



1st Revision: August 2021

Introduction

Preventing the spread of COVID-19 in long-term care homes (LTCHs) and retirement homes (RHs) is critical for the health of residents, health care workers and other staff. Given the volume of guidance, infection prevention and control (IPAC) resources and direction that homes have received, this document has been developed to provide a compilation of important resources and information.

The information in this document has been organized similarly to the sections in the Public Health Ontario's [COVID-19 IPAC Checklist for Long-Term Care and Retirement Homes](#) in order to provide complementary information and resources that can assist with ensuring implementation of IPAC best practices.¹

This document is to be used in addition to—and does not replace—the advice, guidelines, recommendations, directives or other direction of provincial Ministries and local public health authorities. Homes may also want to review Public Health Ontario's [COVID-19 Long-Term Care Resources](#) for more information.² Please note that with COVID-19 vaccination, some IPAC measures will be changed so always refer to current information.

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Ministry Directives and Guidance

Directives and relevant guidance from the government of Ontario for long-term care and retirement homes are to be followed related to many sections in this document. As these are revised often, always ensure that the most recent version is viewed. These can be found on the Ministry website: [Ministry's COVID-19 Guidance for the Health Sector](#).³

IPAC Program

Key IPAC Program Components

An effective and adequately resourced IPAC program is essential to improving resident and health care provider safety by preventing the occurrence or limiting the spread of healthcare acquired infections. The key components of an IPAC program are described in the first resource below. IPAC policies and procedures must be in place that are consistent with relevant legislation and standards and based on sound scientific knowledge. These policies are to be reviewed and updated annually or sooner if needed, and linked to educational programs.

IPAC Professional

The IPAC program must be the responsibility of at least one designated person who has received adequate training in IPAC (such as an endorsed novice IPAC course) and preferably who is certified in IPAC by the Certification Board of Infection Control and Epidemiology (CBIC) available at <https://www.cbic.org/>. Regardless of the size of the facility, the weekly time commitment that is dedicated to infection prevention and control must be clearly stated and protected. The IPAC Professional should have senior leadership support and sufficient resources to carry out the responsibilities of the role.

IPAC Committee

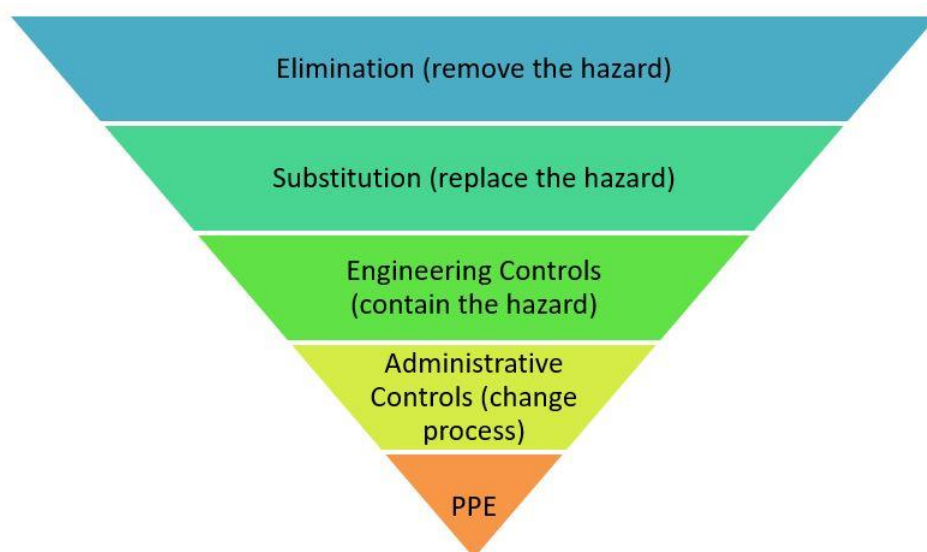
LTCHs should have a formal, multidisciplinary committee to oversee the activities of the IPAC Program or at the very least, include IPAC as a standing agenda item on another formal committee. Membership could include the IPAC professional, a physician representative, an Occupational Health & Safety (OHS) representative (or member of the JHSC), a Public Health representative, an Environmental Services representative and a nursing/clinical representative. This committee could also function as an Outbreak Management Team (OMT) during any outbreak situations. There should be an established communication process between this committee and any Patient/Family Advisory committee or council.

Resources

- Public Health Ontario:
 - [Best Practices for IPAC Programs in Ontario In All Health Care Settings, 3rd edition](#)⁴
 - [IPAC for Long-Term Care Homes Summary of Key Principles and Best Practices](#)⁵
- Ministry of Health and Long-Term Care: [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁶

Hierarchy of Controls

IPAC and OHS need to liaise on a regular basis and work together collaboratively. According to the United States Centers for Disease Control and Prevention's [National Institute for Occupational Safety and Health](https://www.cdc.gov/niosh/topics/hierarchy/default.html) (NIOSH), a fundamental method in the protection of workers is the application of the hierarchy of hazard controls.⁷ These control measures need to be considered and applied as part of the IPAC program with the higher tiers being the preferred measures and Personal Protective Equipment (PPE) being the last option.



Source: National Institute for Occupational Safety and Health (NIOSH).⁷ Hierarchy of controls [Internet]. Atlanta, GA: Centers for Disease Control and Prevention; 2015 [cited 2021 Jul 12]. Available from: <https://www.cdc.gov/niosh/topics/hierarchy/default.html>. Adapted with permission available from: <https://stacks.cdc.gov/view/cdc/44301>

Resources

- Public Services Health and Safety Association: [Infectious Disease Threats Risk Assessment Tool for Acute Care](#)⁸
- Public Health Ontario: [IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#)⁹

Acknowledging and Preventing Harms

Many IPAC and public health measures used to prevent the transmission of COVID-19 in homes can have unintended, significant impacts on the quality of life of residents and families. While following these measures, homes should make every effort to minimize the negative impacts on residents and families. Consultation with Public Health and other partners/experts such as Public Health Ontario or the Ministry of Long-Term Care can identify strategies that can be used for this purpose.

Immunization

Homes should have an immunization policy in place. Two doses of mRNA COVID-19 vaccines are strongly recommended for all staff and residents as the single most important and effective infection mitigation tool. Immunization rates for COVID-19 vaccines and others such as influenza must be documented and maintained for all residents and staff. Public Health Units (PHU) will support local homes with their immunization programs.

Resources

- Public Health Ontario:
 - [Interim Guidance on Infection Prevention and Control for Health Care Providers and Patients Vaccinated Against COVID-19 in Hospital and Long-Term Care Settings](#)¹⁰
 - [COVID-19 Vaccines](#)¹¹

Preparedness Assessment and Outbreak Planning



LTCH/RH, in preparation for potential outbreaks of infectious diseases (e.g., influenza, norovirus, COVID-19) should review their preparedness, develop an outbreak/pandemic plan, educate their healthcare workers and staff and implement infection prevention and control measures to avoid an outbreak.

Identify a lead and a multi-disciplinary outbreak management team. An IPAC Organizational Risk Assessment ([Appendix A](#)) can help provide a framework for the IPAC components of an outbreak plan. The risk assessment can help an organization identify internal and external infectious risks and help determine the likelihood of facing those risks. Consider the risk of exposure to an infectious disease and potential for transmission to all those who live in or work/volunteer at the LTCH/RH and finally consider the controls you already have in place and if these controls would be effective in mitigating the potential transmission and what changes would have to be made to improve the ability to mitigate transmission.

An organizational risk assessment should be performed on an annual basis and as needed or as threats evolve. This allows you to re-evaluate your action plan and assess the effectiveness of control strategies. Having a current outbreak/pandemic plan is important in being able to manage outbreaks/pandemics quickly and effectively as well as having sufficient resources to support control measures. The outbreak plan should include the performance of annual exercises so that staff are prepared and knowledgeable about the steps to take when an outbreak is suspected.

Resources

- Ministry of Health and Long-Term Care: [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁶

Entrance and Screening

Passive Screening



There is signage at the entrance prompting health care workers (HCWs), other staff and essential visitors to self-assess and self-identify if they have signs and symptoms of COVID-19 or another infectious disease. The signage reminds those entering the facility to perform hand hygiene as they enter the home, follow respiratory etiquette while in the home and follow any universal masking/source control. Homes can print off signs in the Resources section below. Ensure there is ABHR with 70%-90% alcohol concentration, masks, tissues and a hands-free garbage bin at the entrance.

Active Screening

Conduct active screening at the entrance and have a process to ensure that all persons entering the home are screened and visits are logged at all times. A screener should be behind a physical barrier, such as a polycarbonate sheet or keep a distance of two meters. If this is not possible, the screener is required to wear personal protective equipment (PPE) per Droplet and Contact precautions. The screener actively screens all HCWs, other staff and essential visitors, with the exception of emergency first responders, following current Ministry of Health screening criteria. Provide education on hand hygiene and masking to all visitors. Staff or visitors who fail screening should not be permitted entry in the home and instructed to either get tested or speak with their supervisor (for staff). Actively screen all residents for signs and symptoms of COVID-19.

Visitors Policy

Follow the most current guidance related to visitors. Have a visitor policy and ensure procedures are communicated to all types of visitors.

Resources

- Public Health Ontario:
 - [Hand Hygiene for Health Care Settings Fact Sheet](#)¹²
 - [How to Self-Monitor](#)¹³

Universal Masking (Masking for Source Control)



Currently, all HCWs, other staff and essential visitors must wear a medical (surgical/procedure mask) for the duration of their shift or visit inside. Scenarios on how and when to apply masks are provided below. It is strongly recommended that residents wear masks in common indoor areas in the LTCH as tolerated. Follow current guidance related to other universal equipment use such as eye protection.

Resources

Public Health Ontario:

- [Universal Mask Use](#)¹⁴
- [Universal Mask Use in Health Care Settings and Retirement Homes](#)¹⁵

Human Resources



Review staffing schedules, HCWs and other staff who work in other locations, availability of alternate staff and emergency contact numbers for staff. Long-term care home employers may be required to limit workplace locations for staff who are not fully immunized, in accordance with legislation. If in outbreak, assess daily essential HCW counts and reach out to the Health Care Provider Hotline 1-866-212-2272 or EOCLogistics.MOH@ontario.ca.

Resources

- Government of Ontario: [Health Workforce Matching Portal](#)¹⁶

Staff Education



Education, both at orientation and on a continuing basis, supports HCWs and staff to consistently implement IPAC practices. Regular audits of IPAC practices, such as staff compliance with hand hygiene, donning and doffing of PPE and equipment/environmental cleaning practices, help to identify areas of focus when preparing for staff training and education. Ensure all staff have been trained in these areas. The short PPE videos in the Resources section are quick refreshers that can be used.

Resources

General:

- [Infection Prevention and Control Fundamentals](#)¹⁷
- [Core Competencies](#): Comprehensive IPAC online training modules with LTC/RH sector-specific information¹⁸

Hand Hygiene: Perform according to 4 moments and as part of PPE donning and removal.

- Videos available on PHO website:
 - [How to Hand Rub](#)¹⁹
 - [How to Hand Wash](#)²⁰
- [How to Hand Rub Sign](#)²¹
- [How to hand Wash Sign](#)²²

Personal Risk Assessment: Perform prior to each resident interaction to determine what PPE is needed.

- [Performing a Risk Assessment Related to Routine Practices and Additional Precautions](#)²³
- [Personal Risk Assessment in Long-Term Care Online Learning](#)¹⁸

PPE: Use PPE as determined by a personal risk assessment or clinical syndrome/condition (e.g., droplet/contact precautions for new admission or transfer)

- [Recommended Steps for Putting On and Taking off PPE](#)²⁴
- Videos available on PHO website:
 - [Putting on Mask and Eye Protection](#)²⁵
 - [Taking off Mask and Eye Protection](#)²⁶
 - [Putting on Full Personal Protective Equipment \(facial protection, gowns and gloves\)](#)²⁷
 - [Taking off Full Personal Protective Equipment \(facial protection, gowns and gloves\)](#)²⁸
 - [Putting on Flatfold N95 Respirator](#)²⁹
 - [Taking off Flatfold N95 Respirator](#)³⁰
 - [Putting on Cone N95 Respirator](#)³¹
 - [Taking off Cone N95 Respirator](#)³²

Environmental Cleaning:

- [Environmental Cleaning Toolkit](#)³³
- [Health Care Huddles: IPAC Checkpoints](#)³⁴
- [Cleaning and Disinfection of Reusable Eye Protection](#)³⁵

Hand Hygiene



Hand hygiene is a key practice for health care workers (HCWs), other staff, residents and visitors to prevent transmission and spread of COVID-19. HCWs, other staff and essential visitors receive education and training on how and when to perform hand hygiene. Hand hygiene products, such as alcohol-based hand rub (ABHR), in a concentration of 70-90% alcohol, are to be located in multiple areas, such as the entrance, point of care and resident common areas. Hand care is also important to prevent damage to hands that can occur with frequent hand washing.

Resources

Public Health Ontario

- [Best Practices for Hand Hygiene in All Health Care Settings, 4th edition](#)³⁶
- [Hand Hygiene](#)³⁷
- [Placement Tool for Hand Hygiene Products](#)³⁸
- [Infection Prevention and Control Practices for Occupational Contact Dermatitis](#)³⁹
- [Hand Hygiene for Health Care Settings Fact Sheet](#)¹²

Consumable Supplies and PPE



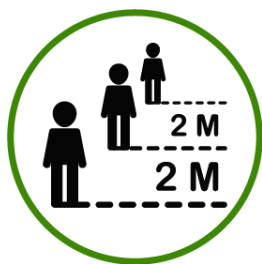
Ensure your facility has sufficient PPE and swabs for testing. PPE includes gloves, gowns, surgical/procedure masks and protective eyewear, as well as N95 respirators for any aerosol-generating medical procedures (AGMP). Fit testing for N95 respirators must be performed at least every 2 years. Consider securing your PPE stock in a central location and developing a way to track supplies and usage. If supplies are running short, such as the facility only has a few days of stock left or the home needs to start extending the use of PPE, contact your Ontario Health representative.

Resources

The Centers for Disease Control and Prevention

[PPE Burn Rate Calculator](#)⁴⁰

Physical Distancing



Physical distancing is considered one of the most effective preventative strategies by the [World Health Organization \(WHO\)](#).⁴¹ Maintaining physical distancing (maintaining a minimum 2 metre [6 foot] distance apart, as much as possible) between all HCWs, other staff and essential visitors, general visitors and residents is critical. HCWs, other staff, essential visitors and general visitors are to receive education and training on physical distancing. Exceptions to physical distancing are described in the Ministry guidance.

Strategies to support HCW and other staff physical distancing include: the use of outdoor spaces as weather permits, increasing the number of places identified as break/lunchrooms, limiting the number of tables and chairs in staff common areas, placing the tables 2 metres apart, placing the chairs at the table such that a 2 metre distance between chairs is maintained between those at the table and adjacent tables, and choosing meeting spaces that will allow 2 metre distance between attendees and/or holding multiple meetings with smaller number of attendees (e.g., huddles on a resident care unit).

Strategies that may be used to support the physical distancing of residents include: educating residents on physical distancing, moving or removing chairs to ensure there is no cluster seating, removing or spacing out tables/chairs in dining room(s), having multiple sittings in the dining room(s), suspending group activities unless groups are small, maintaining two (2) metre (six feet) distancing throughout activity in non-outbreak homes, and monitoring elevator waiting spaces to ensure two (2) metre (six feet) distancing. Consider placing markers on the floor where residents may queue (e.g., at the elevator), ensure the physical layout of resident rooms allows for sufficient space between resident environments (e.g. bed, furniture, fixtures, shared washroom), and separate resident spaces by partitions or drawn curtains. In the time of an outbreak in the home/unit, all meals are eaten in residents' rooms. In addition, review residents' medication administration schedules to minimize the number of times HCWs need to enter residents' rooms.

Resources

Public Health Ontario:

- [How to Physically Distance in Long-term Care Home](#)⁴²

Planning and Outbreak Management



Ensure your home has identified a person(s) to liaise with the local PHU and that the name and contact information of the PHU contact person(s) is known. There needs to be a process in place to communicate with residents, families, HCWs and staff with respect to an outbreak. Establish and maintain processes for inter-facility transfers that includes notifying both the transport personnel and the receiving facility of the resident's COVID-19 status or any other communicable disease/condition.

Resources

Ministry of Health: [Public Health Unit Locations](#)⁴³

Testing Residents, HCWs and other Staff



Testing of residents, HCWs, other staff and essential visitors is performed in accordance with the Ministry's directive and guidance for testing. Refer to the Public Health Ontario Laboratory website in the Resources section for more details on specimen collection, handling and submission.

Resources

[Public Health Ontario COVID-19 Laboratory Testing Resources](#)⁴⁴

Surveillance



Continue monitoring of all residents and HCWs, other staff and essential visitors in the home for new symptoms. Active screening described above is important for ongoing surveillance. Follow any additional requirements such as asymptomatic testing. Continue to screen for symptoms of all residents in the home. Look for symptoms, including atypical, and keep a low threshold for testing. Maintain and submit line lists for residents and staff to your local PHU using the method it has prescribed to you and following guidance from the first resource below.

Identification of residents, HCW, other staff or essential visitors with new symptoms compatible with COVID-19 requires an outbreak assessment by the local PHU per current outbreak definitions.

Occupational Health & Safety

All staff are to self-monitor while at work or at home. HCWs, other staff and essential visitors who become ill or symptomatic are to immediately self-isolate, inform their supervisor and if at work, return home. They must also contact their primary care provider, Telehealth or local PHU. HCWs, other staff and essential visitors should not to work/visit at more than one LTCH/RH if not fully immunized.

Droplet and Contact Precautions

Immediately place a symptomatic resident on Droplet/Contact precautions, as well as any close contacts. If it is not possible to transfer the ill resident to a private room, then pull the privacy curtain and maintain a 2 m (6 ft.) spatial separation between adjacent beds. HCWs, other staff or essential visitors that become symptomatic while at the home are to immediately leave and self-isolate.

Resources

Ministry of Health and Long-Term Care:

- [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁶

Public Health Ontario:

- [PHO Laboratory Services: Coronavirus Disease 2019 \(COVID-19\) – PCR](#)⁴⁵
- [How to Self-Monitor](#)¹³
- [Droplet and Contact Precautions Non-Acute Care Facilities](#)⁴⁶
- [Droplet and Contact Precautions Signage](#)⁴⁷
- [IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#)⁹
- [Scenarios for Universal Masking and Other PPE \(gowns and gloves\)](#)¹⁵

Resident and HCW Cohorting



LTCH and RH are to use HCW and resident cohorting to prevent the spread of COVID-19. Planning space for cohorts in the event of an outbreak should be part of the organizational risk assessment. Cohorting can be done by assigning a geographic area, such as a room or a resident care area, to two or more residents. HCWs can be assigned to work with cohorts of residents by their COVID-19 status (positive, negative but exposed, recovered) or when not in outbreak to consistent areas. This must be a clear separation and also include the environmental/housekeeping staff. In non-outbreak situations, cohort residents in small groups for dining and social activities.

Resources

Ministry of Health and Long-Term Care:

- [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁶

Public Health Ontario:

- [How to Self-Isolate while Working](#)⁴⁸
- [Cohorting During an Outbreak of COVID-19 in Long-Term Care Homes](#)⁴⁹
- [Examples for Resident Cohorting in Long-Term Care Homes](#)⁵⁰

Resident Admissions and Re-Admissions



All admissions or re-admissions are organized according to the most current Ministry guidance. Requirements for residents to be tested and for isolation (i.e., placed on Droplet/Contact Precautions) on arrival should follow current Ministry guidance.

Declaring the Outbreak Over

The Medical Officer of Health or designate (from the local PHU) in collaboration with the home's Outbreak Management Team will determine when to declare an outbreak over.⁶ The outbreak may be declared over when there are no new cases in residents or staff after 14 days (maximum incubation period) from the latest of:⁵¹

- Date of isolation of the last resident case OR
- Date of illness onset of the last resident case OR
- Date of last shift at work for last staff case

Ensure to:

- Terminally clean resident environment
- Communicate that outbreak is over to stakeholders

Resources

Ministry of Health and Long-Term Care: [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁶

Ministry of Health: [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#)⁵²

Public Health Ontario: [De-escalation of COVID-19 Outbreak Control Measures in Long-term Care and Retirement Homes](#)⁵³

Environmental Cleaning



Environmental Services staff (especially any temporary or redeployed ones) need training on how to perform environmental cleaning properly. Perform frequent cleaning and disinfection of high touch surfaces at a minimum of once daily and twice daily if in outbreak. Continue to use healthcare/hospital disinfectants (e.g., with a Drug Information Number) and follow the instructions for correct contact times. More detailed information on practices can be found in the appendices of PIDAC's Best Practices for Environmental Cleaning. Initiate dedicated housekeeping staff for the outbreak unit or areas, if possible. Clean and disinfect COVID-19

negative rooms first before moving into an area with COVID-19 positive residents.

Cleaning and Disinfection

Clean and disinfect shared resident care equipment between each resident and according to the manufacturer's instructions and best practices. Clean and disinfect thermometers for temperature checks after each use and discard single use probe covers.

Resources

Ministry of Health and Long-Term Care:

- [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁶

Public Health Ontario:

- [PHO Environmental Cleaning Resource Page](#)⁵⁴
- [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition](#)⁵⁵
- [Environmental Cleaning Toolkit](#)³³
- [Spaulding's Classification of Medical Equipment/Devices and Required Level of Processing/Reprocessing](#)⁵⁶

Auditing

There should be a process to audit or monitor hand hygiene, Routine Practices, Additional Precautions, PPE use (e.g., how one dons and doffs), and environmental cleaning. The [COVID-19 IPAC Checklist for Long-Term Care and Retirement Homes](#) can be used as an audit tool.¹ Other resources for completing audits are listed below.

Resources

Public Health Ontario:

- [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition](#)⁵⁵
- [Just Clean Your Hands – Long-term Care](#)⁵⁷

Appendix A

Organizational IPAC Risk Assessment

An IPAC organizational risk assessment (ORA) can help provide a framework for the IPAC components of an outbreak plan. The risk assessment can help an organization identify areas of strength, weakness, threat and opportunities for improvement to mitigate risks. The Public Services Health and Safety Association has developed a document Infectious Disease Threats Risk Assessment Tool for Acute Care, which may be used as a reference.⁸ Below is a list of IPAC elements to consider when performing an ORA in LTC/RHs. Some resources are embedded in the questions. Additional resources that may assist in performing an organizational risk assessment are listed at the end.

The LTCH's/RH's context

- Where is your LTCH/RH? Are you in a large city or a small town?
- What services does your LTCH/RH provide?
- Do you have access to a regional health centre or other health systems?
- What health sector coordination mechanisms do you already have in place to manage emergencies?
- What is your resident demographic?
- Consider your organizations values, beliefs and strategic plan⁸
- Staff safety culture and engagement⁸
- Reports of existing illnesses and points of exposure⁸
- Ongoing monitoring of infectious disease threats in the community and beyond^{8,58}

IPAC Program

- Does the home have an IPAC Program?⁴
- What are the IPAC lines of authority within your organization?
- Is there a person(s) responsible for IPAC?
- Is there a multi-disciplinary team responsible for outbreak management?
- Do those responsible for IPAC have support (i.e., resources [e.g., time, funding], senior leadership) to carry out necessary activities?
- Do you have established IPAC policies and procedures?

Human Resources

- Does the home have sufficient human resources for the provision of care and support services (e.g., environmental cleaning and dietary services)?
- Has a contingency plan with respect to human resources been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities and essential facility operations?⁵⁹
- Would it be possible to re-deploy some human resources in an outbreak?

Communication

- Does your home have an outbreak management communication protocol to connect with families and residents, other facilities in your area and/or the media?⁶
- Does your home have a process for inter-facility transfers that includes notifying transport personnel and receiving facilities about a resident's suspected or confirmed diagnosis (e.g., presence of respiratory symptoms or known COVID-19) prior to transfer?⁶

Identify Risks

Consider the potential infectious diseases that could impact your organization as a long-term care home. Organisms that frequently cause outbreaks include: influenza A and B, respiratory syncytial virus (RSV), human metapneumovirus, parainfluenza, norovirus, seasonal coronavirus, *Clostridioides difficile*, methicillin resistant *Staphylococcus aureus* (MRSA). Also consider emerging pathogens such as *Candida auris* or SARS-CoV-2.

- Which residents and/or employees could be exposed to by these organisms?
- Does the type of work performed by the employee increase their risk of exposure?
 - Resident Care, Environmental Services and Waste Management, Linen/Laundry, Food Services, Activation, Physiotherapy
- What would be the risk to the employee should they incorrectly select, don or doff personal protective equipment?
- How could these organisms impact these groups of residents and/or employees?

Analysis of Risk

Here, think about all the potential controls that are already in place in your organization – think about them in terms of the hierarchy of controls (elimination/substitution, environmental controls, administrative controls, controls at the worker [PPE]) and in the context of which organisms are mostly like to cause an outbreak in your home. What are the internal (infrastructure, home IPAC policies and procedures, health care worker education/training to the policies and procedures, and then health care worker compliance, vaccination of staff and residents, adequate staffing), and external factors (funding, access to adequate supplies of PPE) that would influence the ability to implement control strategies? Below are various IPAC strategies that can be considered to mitigate risk. While reviewing the IPAC strategies – think about your organization and how these apply or are implemented there.

Infrastructure/Design – Provision of Care

- Does the design/infrastructure of your LTCH/RH facilitate IPAC, such as cohorting?⁶
- Is the home primarily single rooms or do you have multiple semi-private or ward rooms?
- What is the home's ability to place a single resident on Additional Precautions (e.g., Droplet/Contact precautions) that require a single room?
- Have alternative accommodation plans been considered to support IPAC measures, such as:
 - Respite and palliative beds/rooms to provide additional accommodations
 - Other rooms to help maintain isolation of affected residents (e.g., community and recreation rooms that have call bells)

Environmental Cleaning

- Are there policies and procedures regarding staffing in Environmental Services to allow for surge capacity (e.g., additional staff, supervision, supplies and equipment)?
- Have the Environmental Services (ES) staff received education and training on the correct way to clean (e.g., use the correct dilution, correct contact time, clean from clean to contaminated and from top to bottom, do not double dip)?
- Is there a policy and procedure for cleaning rooms of residents who are on Droplet/Contact precautions (suspect and confirmed cases)?
- Is the home using a health care grade cleaner/disinfectant with a drug identification number (DIN)?
- Is equipment that cannot be dedicated to a single resident cleaned and disinfected between residents?
- Have the HCWs received education and training on the correct way to clean equipment that is used on multiple residents (e.g., use the correct dilution, correct contact time, clean from to contaminated and from top to bottom, do not double dip)?
- Are high-touch surfaces cleaned frequently? Is there is a list of the high-touch surfaces, who is cleaning them and when? Is this information recorded daily?

Hand Hygiene

- Is hand hygiene, supported with ABHR, available at point-of-care and in other resident and common areas?
- Are hand hygiene sinks available in all resident care areas?
- Are hand hygiene supplies maintained/replenished when needed?
- Are audits of hand hygiene compliance performed?

Education

- Are HCWs, staff, students and volunteers educated with respect to IPAC processes and strategies (e.g., hand hygiene, point-of-care risk assessment, Routine Practices, Additional Precautions, donning and doffing of PPE, Healthy Workplace policy, cleaning/disinfection of resident care equipment)?^{4,36, 60}
- Does this education occur at orientation and on a continuing basis?
- Are residents educated with respect to hand hygiene?
- The PHO's [Infection Prevention and Control Fundamentals](#) document provides a list of educational resources.¹⁷

Surveillance

Do you have a surveillance program in place (e.g., surveillance for acute respiratory infections and gastroenteritis)?^{6,61} The Ministry of Health and Long-Term Care's [Contol of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#) can provide guidance on surveillance.⁶

- Have the HCWs received education and training on their role in the surveillance program?
- If a resident presents with symptoms of COVID-19, do staff know to immediately implement Droplet/Contact precautions?
- Does the organization connect with the local PHU regarding surveillance?⁶¹
- How does your internal IPAC lead/team interact with external bodies and authorities (e.g., Public Health Ontario, local PHU, etc.)?
- Who is the organization's PHU liaison? Do you have their contact information?
- Who will have input and approve your plans?

Testing for COVID-19 or Other Respiratory Viruses

- Does the home have a process in place for ordering tests kits/requisitions?
- Does the home have a supply of COVID-19 test kits?
- Is there a policy and procedure on nasopharyngeal (NP) swab collection?⁵²
- Have HCWs been educated and trained on NP swab collection?

Personal Protective Equipment (PPE)

- Is PPE readily accessible to HCWs, including N95 respirators, if facility has AGMP (control at the worker)?^{7, 60}
- Are HCWs and staff educated with respect to which PPE should be worn when providing care for a resident on Droplet/Contact precautions and how to safely don and doff the PPE?

Assess the Risk

In this step, the organization assesses how likely it is an event will happen (e.g., influenza A outbreak) and the impact of that event on the residents and staff of the organization. A Risk Assessment Matrix may be helpful in assessing the risk.

Risk Assessment Matrix

	Severity rating				
Likelihood rating	Negligible (1)	Minor (2)	Moderate (3)	Severe (4)	Critical (5)
Very likely (5)	Medium (6)	Medium (7)	High (8)	High (9)	High (10)
Likely (4)	Medium (5)	Medium (6)	Medium (7)	High (8)	High (8)
Possible (3)	Low (4)	Medium (5)	Medium (6)	Medium (7)	High (8)
Unlikely (2)	Low (3)	Low (4)	Medium (5)	Medium (6)	Medium (7)
Highly unlikely (1)	Low (2)	Low (4)	Low (4)	Medium (5)	Medium (6)

Source: Public Services Health & Safety Association.⁸ Infectious disease threats risk assessment tool for acute care [Internet]. Toronto, ON: Public Services Health & Safety Association; 2020 [cited 2021 Jul 12]. Part 2 – Conducting an infectious disease threat organizational risk assessment (IDT ORA); Risk assessment matrix; p. 12. Available from: <https://www.pshsa.ca/resources/infectious-disease-threats-risk-assessment-tool-for-acute-care#home-pshsa-logo>

Manage Risks

Consider the risks your organization has identified and needs to manage. What standards or criteria will be used to determine if the risk is being managed?⁸ That the strategies for mitigating the impact of that risk are being followed/carried out? For example, if there a risk of an MRSA outbreak and failure to use Contact Precautions (i.e., resident placed in single room; dedicated resident care equipment; gloves and gowns worn for direct care; hand hygiene performed as per the Four Moments for Hand Hygiene), an organization could implement the use of audits to assess compliance to resident placement, the management of resident care equipment including the cleaning/disinfecting of equipment between residents, the correct use of PPE, and compliance to hand hygiene.

Evaluation

On a regular basis and as infectious disease threats (IDTs) change, evaluate your ORA⁸. Consider which IDTs remain or have changed and if the IPAC strategies in place are preventing transmission in your organization.

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Summary of Revisions

The evidence in this document is current to June 30, 2021. New material in this revision is summarized in the table below.

Summary of amendments in 1st revision:

Revision Number	Date of Implementation	Description of Major Changes	Page
1	June 30, 2021	Overall format of document changed as headings arranged to follow LTC/RH checklist format	All
2	June 30, 2021	Edits to content based on updated Ministry guidance	All
3	June 30, 2021	Resources updated for some sections	All
4	June 30, 2021	Additional sections added to provide information on IPAC programs including immunization	3-5
5	June 30, 2021	Include graphic on risk assessment	21
6	July 9, 2021	Update references	22-24

Publication History

Published: June 15, 2020

1st Revision: August 17, 2021

Citation

Ontario Agency for Health Protection and Promotion (Public Health Ontario). Prevention and management of covid-19 in long-term care and retirement homes. 1st revision. Toronto, ON: Queen's Printer for Ontario; 2021.

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