



# COMMUNITY SHELTERS INFECTION PREVENTION AND CONTROL RESOURCE MANUAL

NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT

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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).<sup>10</sup>

**Blood Borne Infection:** An **infection** transmitted through contact with infected blood or other potentially infectious body fluids. <sup>4</sup>

**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.<sup>10</sup>

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

**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. <sup>10</sup>

**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**. <sup>10</sup>

**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. <sup>10</sup>

**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 an alcohol-based hand rub (ABHR) that is 70-90% alcohol based.<sup>10</sup>

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

**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.<sup>10</sup>

**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.<sup>10</sup>

**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. <sup>10</sup>

**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.<sup>10</sup>

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

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

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

**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.<sup>10</sup>

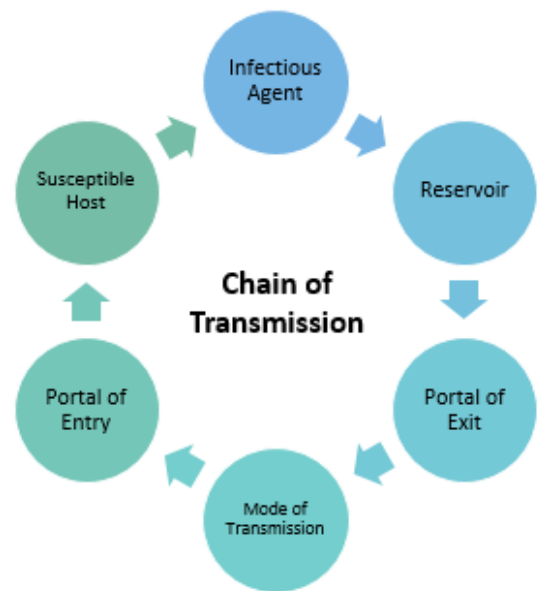
## INTRODUCTION

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



## CHAIN OF INFECTION <sup>12</sup>

In order 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 is able to 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 <sup>8, 11</sup>

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 publically funded vaccinations. Appropriate vaccines for susceptible community shelter employees, volunteers and students include:

- Influenza vaccine
- Measles, mumps, rubella (MMR) vaccine
- Varicella vaccine
- Hepatitis B vaccine
- Pertussis vaccine
- Meningococcal vaccine
- Tetanus/diphtheria vaccine

For further information regarding immunizations contact the Vaccine Preventable Diseases Department, see [Appendix A](#).





## ROUTINE PRACTICES<sup>11</sup>

**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:

1. **Risk assessment** - 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.

2. **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.
3. **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 performed after removing **PPE**, including after glove use.



## USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE) <sup>11</sup>

### 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 eye glasses are not acceptable eye protection
- If prescription eye glasses 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 <sup>10</sup>

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 Us](#)). 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 community shelter setting, the role of environmental **cleaning** is important because it reduces the number and amount 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 **environment of the client**. 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 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., MRSA, VRE, *C.difficile*, influenza virus and others) in a community shelter 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 community shelters. 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 G](#) 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 a Public Health Inspector on the Environmental Health Team (see [Appendix A: How to Reach Us](#)) 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 DISINFECTING

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

Community shelters **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**

Community shelters 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 G](#) for a summary of cleaning and disinfecting in community shelters.

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

## EXPOSURE TO BLOOD AND BODY FLUIDS <sup>4</sup>

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 <sup>12</sup>

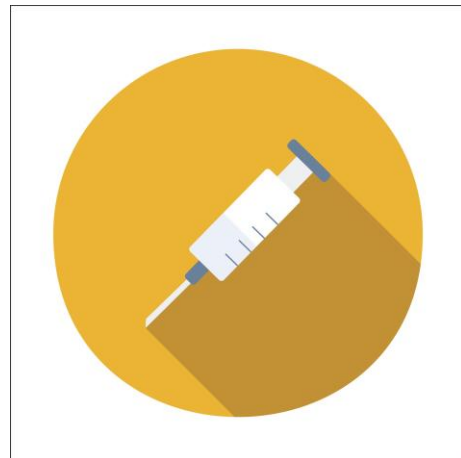
Sharps are items that can cut or puncture the skin such as knives, broken glass, razor blades and needles. Sharps may be contaminated with infectious materials. If the skin is punctured with a contaminated sharp, **infection** can occur.

It is important for community shelters 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 be puncture-resistant, leak proof, designed to easily place items in the container and so that it is difficult to remove contents from the container, guard against accidental entry of other materials, labelled as a “biohazardous materials” and designed for safe transportation.

Things to remember about sharps:

- Keep sharps containers as close to the working space as possible
- 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  $\frac{3}{4}$  full



## OUTBREAKS <sup>6,7</sup>

Due to the close living and sleeping quarters, community shelters 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. See [Appendix A: How to Reach Us](#), for information on how to report suspect or confirmed outbreaks. 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 Health Unit Contact Information.

## OUTBREAK MANAGEMENT AND THE ROLE OF THE HEALTH UNIT

When the health unit is contacted about a possible outbreak, a public health nurse (PHN) in the Communicable Disease Control program will obtain further information on the clients in the shelter (e.g., how many are ill, what their symptoms are, when they started, and how many are living in the shelter) in order to confirm whether an outbreak is occurring.

The health unit also conducts community surveillance and may notice an increase in a particular disease associated with a community shelter. In this case, the community shelter will be contacted by the health unit to discuss the possibility of an outbreak.

The PHN you speak with will make recommendations on control measures to implement to interrupt the spread of illness and stop the outbreak. Examples of control measures to limit the spread of **infection** include communication of the outbreak to all staff, clients and volunteers; **infection** prevention and control precautions (e.g. PPE); and environmental **cleaning** and **disinfection**. The PHN will go over the control measures with you over the phone and will fax a list of recommendations to you for your records. Refer to [Appendix C: Quick Reference to Detecting & Managing Outbreaks](#) or [Appendix D: Quick Reference to Detecting COVID-19 Outbreaks](#) for further information.

For gastroenteritis outbreaks, the PHN will also contact the Environmental Health Program and speak with a Public Health Inspector about the possible need for an inspection if contaminated food and/or water is suspected to be causing the outbreak.

If an outbreak is confirmed, you will need to update the PHN on a daily basis of any new cases, any clients who recover, any clients who are hospitalized and any staff illnesses. This information assists the PHN in assessing the outbreak status and is required in order to determine when the outbreak can be declared over.



## TUBERCULOSIS (TB) <sup>2, 3, 9</sup>

### 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 lungs 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.

### 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 disease:

- Coughing for more than 2-3 weeks
- Coughing up blood/phlegm
- Fever/chills/night sweats
- Weakness/tired
- Unexplained weight loss/loss of appetite
- Other symptoms depending on site of TB



#### Testing for LTBI and 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

## TUBERCULOSIS (TB) SCREENING RECOMMENDATIONS FOR EMPLOYEES AND VOLUNTEERS

TB screening is recommended upon initial hire or placement for all employees and volunteers. A volunteer is defined as one who expects to work 150 or more hours during the year.

Supplying agencies or schools are responsible for pre-placement TB assessment and follow-up prior to starting the placement.

**The following assessment must be initiated upon hire or placement:**

Current Status of Employee and/ or Volunteer	Initial Assessment	Results-What to do next
Person with Unknown or undocumented TST	A 2-step TST is required	<p>If both TSTs are negative annual TST is recommended</p> <p>If either TST is positive refer to *Person with a positive TST</p>
Person with documented results of previous 1-step TST	<p>If test was negative and done &gt;12 months ago a 2-step TST is necessary</p> <p>If test was negative and done &lt;12 months ago a 1-step TST is required</p> <p>If test was positive see section *Person with a positive TST</p>	<p>If tests are negative annual TST is recommended</p> <p>If either test is positive refer to *Person with a positive TST</p>
Person with documented results of previous 2-step TST	<p>If both tests were negative and done &gt;12 months ago a 1-step TST is necessary</p> <p>If both tests were negative and done &lt;12 months ago No further testing is recommended</p>	<p>If both tests are negative annual TST is recommended</p> <p>If either test is positive refer to *Person with a positive TST</p>

\*Person with a positive TST

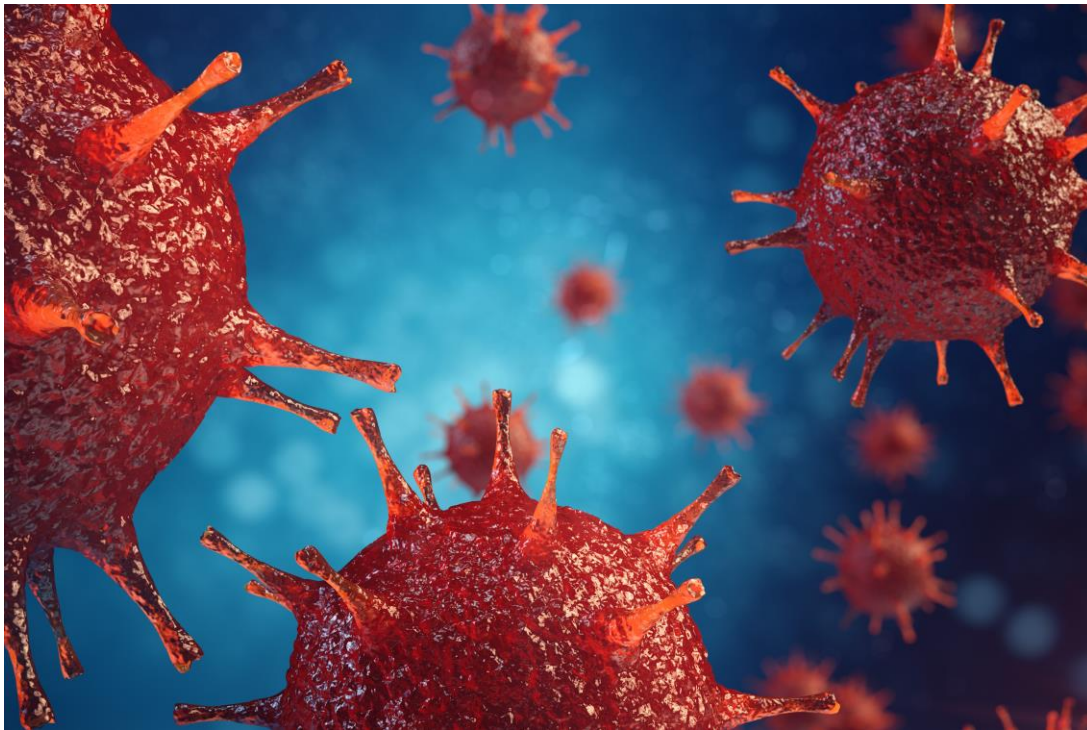
<p>Refer to Health Care Provider for a further assessment (symptom review and a chest x-ray are recommended to rule out active TB disease)</p> <p>Further skin testing is not recommended</p> <p>The person should be informed of the signs and symptoms of active TB disease and advised to promptly report symptoms if they develop</p> <p>Note: Report any employee/volunteer with a new positive TST to the North Bay Parry Sound District Health Unit; see <a href="#">Appendix A</a> for the health unit's contact information</p>	<p>Person should not work until health care provider provides documentation that the person does not have an infectious TB disease.</p>
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Note: Persons with medical conditions that severely weaken the immune system may have a negative TST even though they have TB infection (LTBI).



## REPORTING REQUIREMENTS FOR TB AND OTHER COMMUNICABLE DISEASES <sup>5</sup>

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 North Bay Parry Sound District Health Unit (NBPSDHU) 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 NBPSDHU website at [www.myhealthunit.ca](http://www.myhealthunit.ca). See [Appendix A](#) for the health unit contact information. For a complete list of diseases reportable to the health unit see [Appendix B](#).





## APPENDIX A - HOW TO REACH THE HEALTH UNIT

Program	Contact Information: Monday to Friday, 8:30 to 4:30
<p><b>Communicable Disease Control</b></p> <p>Outbreak Management</p> <p>Infection Prevention and Control</p> <p>Routine Practices and Additional Precautions Information</p> <p>Infectious Disease Reporting and Follow-up</p> <p>Hand Hygiene Education</p>	<p>705-474-1400 ext. 5229</p> <p>After hours call 705-474-1400 and dial 0 to reach the answering service</p>
<p><b>Environmental Health</b></p> <p>Food Safety</p> <p>Environmental Cleaning/Disinfection</p> <p>Private Drinking Water Testing/Results Interpretation</p> <p>Rabies Prevention</p>	<p>705-474-1400 ext. 5400</p>
<p><b>Sexual Health</b></p> <p>Sexually Transmitted Infection Education, Testing and Treatment</p> <p>Birth Control and Emergency Contraception</p> <p>Harm Reduction (including safer sex, needle exchange and safer drug supplies and naloxone kits)</p> <p>Pap Testing</p> <p>Pregnancy Testing and Options Counselling</p>	<p>705-474-1400 ext. 5289</p>
<p><b>Vaccine Preventable Diseases</b></p> <p>Immunizations</p> <p>Travel Health</p>	<p>705-474-1400 ext. 5252</p>
<p><b>Oral Health</b></p> <p>Adult and Child Dental Clinics</p> <p>Oral Screening</p>	<p>Dental Clinic: 704-474-1400 ext. 5227</p> <p>General Information: 705-474-1400 ext. 5328951</p>

## APPENDIX B – DISEASES OF PUBLIC HEALTH SIGNIFICANCE (DOPHS) <sup>5</sup>

For information about any of the diseases of public health significance below, please contact the communicable disease program at 705-474-1400 or 1-800-563-2808 ext. 5229.

### Diseases of Public Health Significance (DOPHS)

**Suspected** or **confirmed** cases of the following specified Diseases (as per Ontario Regulation 135/18 and amendments under the Health Protection and Promotion Act, R.S.O. c.H.7) must be reported to the local Medical Officer of Health.

**IMMEDIATE REPORTING** Given the public health action associated with case and contact follow-up for some DOPHS, it is expected that the following be reported immediately by fax and telephone to the local Medical Officer of Health.

Anthrax	Group A Streptococcal disease, invasive	Meningococcal disease, invasive
Botulism	Haemophilus influenzae disease, all types, invasive	Plague
Brucellosis	Hantavirus pulmonary syndrome	Poliomyelitis, acute
Creutzfeldt-Jakob Disease, all types	Hemorrhagic fevers, including: Ebola, Marburg, Lassa fever, and other viral causes	Q Fever
Diphtheria	Hepatitis A, viral	Rabies
Diseases caused by a novel coronavirus, including COVID-19, Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS)	Measles	Smallpox and other Orthopoxviruses including Monkeypox

**Report by next business day** It is expected that health care providers report to the local Medical Officer of Health as soon as possible, but preferably within one business day.

Acquired Immunodeficiency Syndrome (AIDS)	Food poisoning, all causes	Psittacosis/Ornithosis
Acute Flaccid Paralysis	Gastroenteritis, outbreaks in institutions and public hospitals	Respiratory infection outbreaks in institutions and public hospitals
Amebiasis	Giardiasis, except asymptomatic cases	Rubella
Blastomycosis	Gonorrhea	Rubella, congenital syndrome
Campylobacter enteritis	Group B Streptococcal disease, neonatal	Salmonellosis
Carbapenemase-producing Enterobacteriaceae (CPE) infection or colonization	Hepatitis B, viral	Shigellosis
Chancroid	Hepatitis C, viral	Syphilis
Chickenpox (Varicella)	Influenza	Tetanus
Chlamydia trachomatis infections	Legionellosis	Trichinosis
Cholera	Leprosy	Tuberculosis
Clostridium difficile (CDI) outbreaks in public hospitals	Listeriosis	Tularemia
Cryptosporidiosis	Lyme Disease	Typhoid Fever
Cyclosporiasis	Meningitis; acute, including: bacterial, viral and other	Verotoxin-producing E.coli infection including Haemolytic Uraemic Syndrome (HUS)
Echinococcus multilocularis infection	Mumps	West Nile Virus Illness
Encephalitis, primary, viral	Ophthalmia neonatorum	Yersiniosis
Encephalitis, post- infectious; vaccine-related; subacute sclerosing panencephalitis; unspecified	Paralytic Shellfish Poisoning	
	Paratyphoid Fever	
	Pertussis (Whooping Cough)	
	Pneumococcal disease, invasive	

**Telephone:** 705-474-1400 or 1-800-563-2808 ext. 5229 - Monday to Friday 8:30 am to 4:30 pm **After Hours, weekends and holidays:** Press '0' for Answering Service  
**Fax:** 705-474-2809



## QUICK REFERENCE TO DETECTING & MANAGING OUTBREAKS

### SUSPECT AN OUTBREAK WHEN:

#### RESPIRATORY

There are **two cases\*** within 48 hours in **one area** (i.e., unit or floor)

#### OR

There is **ONE** lab confirmed case of influenza

#### ENTERIC

There are more cases\* than normal, based on surveillance data

### OUTBREAK CONFIRMED WHEN:

#### RESPIRATORY

There are **three cases\*** within 48 hours in **one area** (i.e., unit or floor) **OR**

There are **two cases\*** within 48 hours in **one area** at least **ONE** must be a lab confirmed case of influenza

\*A case is defined as a resident 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)

#### ENTERIC

There are **two cases\*** in a specific area (i.e., unit or floor) within **48 hours**

\*A case is defined as a resident or staff with two or more episodes of vomiting and/or diarrhea in a 24-hour period that cannot be explained by other reasons (e.g., laxatives)

### NEXT STEPS:

- DON'T WAIT, ISOLATE.** Encourage ill residents to stay in their rooms. Follow routine practices in addition to:

#### RESPIRATORY

Contact /Droplet precautions (gowns, gloves, goggles, mask)  
Continue until 5 days after the onset of symptoms or until symptoms resolved if shorter

#### ENTERIC

Contact precautions (gown, gloves). Droplet precautions (mask, goggles) may also be needed (splashes)  
Continue until 48 hours after symptoms have resolved

- Start an *Institutional Outbreak Line Listing*. Use a separate line list for each affected unit and one for staff.

- Contact the Communicable Disease Control Program at the Health Unit.

After Hours/Weekends: 705-474-1400/1-800-563-2808; then press "0" for the answering service.  
During Business Hours: 705-474-1400/1-800-563-2808 ext. 5229 or the CDC staff assigned to your facility.

- Collect specimens from affected residents (sickest and/or newest onset):

#### RESPIRATORY

Up to four nasopharyngeal swabs may be collected during an outbreak; refrigerate and call the Health Unit

#### ENTERIC

Up to five stool specimens may be collected during an outbreak; refrigerate and call the Health Unit

- Advise hospital infection control/receiving facility, EMS workers and transfer agencies of outbreak **prior to** any transfer or outpatient procedures, even if resident is not from an affected area. Transfers between LTCHs during an outbreak are not recommended.

- New admissions and return of residents who have not been line listed are generally not recommended. If admission is necessary, consult with the Health Unit and the facility's infection control contact.

- Symptomatic staff, students and volunteers:

#### RESPIRATORY

Exclude from work for 5 days after the onset of symptoms, or until symptoms resolved if shorter

#### ENTERIC

Exclude from work until 48 hours after symptoms have resolved

Reviewed: January 2020



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### QUICK REFERENCE TO DETECTING & MANAGING OUTBREAKS

#### SUSPECT AN OUTBREAK WHEN:

There is **ONE** lab confirmed case of COVID-19 case in a resident/patient.

#### OUTBREAK CONFIRMED WHEN:

There are **TWO or more** residents and/or staff/other visitors in a home (e.g. floor/unit) each with a positive PCR test OR rapid molecular test OR rapid antigen test result AND with an epidemiological link\*, within a 10-day period.

\*Epidemiological link defined as: reasonable evidence of transmission between residents/staff/other visitors AND there is a risk of transmission of COVID-19 to residents within the home.

#### NEXT STEPS:

1. **DON'T WAIT, ISOLATE.** Encourage ill residents/patients to stay in their rooms. Follow routine practices in addition to:

Droplet and Contact precautions (gowns, gloves, goggles, mask, preferred N95 mask for suspect and confirmed cases of COVID-19).

Continue isolation until 10 days after the onset of symptoms (or 10 days from positive test collection date if asymptomatic). Clearance of cases and release from isolation is at the direction of the local public health unit, guided by Ministry of Health's [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#) and applicable setting specific guidance for [LTCH/Retirement Homes](#), and [Congregate Care Settings](#).

Individuals with a high-risk exposure to the case(s) (including roommates, dining/activity cohort, staff who cared for the case without appropriate and consistent PPE) should follow the advice of the local public health unit for isolation, guided by Ministry of Health's [Management of Cases and Contacts of COVID-19 in Ontario](#), and/or setting specific guidance as listed above.

2. Start an *Institutional [Outbreak Line Listing](#)*. Use a separate line list for each affected unit and one for staff.

3. Contact the Communicable Disease Control Program at the Health Unit.  
During Business Hours: 705-474-1400/1-800-563-2808 ext. 5229 or the CDC staff assigned to your facility. After Hours/Weekends: 705-474-1400/1-800-563-2808; then press "0" for the answering service.

4. Collect specimens from affected residents.

As well, individuals with a high-risk exposure to the case(s) should be tested immediately, and includes roommates, dining/activity cohort, staff who cared for the case without appropriate and consistent PPE.

Repeat testing of all individuals with high-risk exposures who initially tested negative is at the direction of the local public health unit, guided by Ministry of Health's setting specific guidance.

5. Advise hospital infection control/receiving facility, EMS workers and transfer agencies of outbreak prior to any transfer or outpatients procedures, even if resident is not from an affected area.
6. Admission of new residents, transfers and return of residents who have not been line listed to the affected unit/floor is generally not advised. In consultation with the health unit, changes in this measure should be considered carefully with respect to resident safety and quality of life, as was as system capacity.
7. Symptomatic staff, students and volunteers:  
Exclude from the home/facility for 10 days from onset of symptoms, or until COVID-19 is ruled out (i.e. negative COVID-19 test result).

## APPENDIX E - STEPS FOR PUTTING ON AND TAKING OFF PERSONAL PROTECTIVE EQUIPMENT

### Putting on Personal Protective Equipment (PPE)

1. Perform Hand Hygiene
2. Put on Gown
  - a. Tie neck and waist ties securely
3. Put on Mask/N95 respirator
  - a. Place mask over nose and under chin
  - b. Secure ties, loops or straps
  - c. Mould metal piece to your nose bridge
  - d. For respirators, perform a seal-check
4. Put on protective eyewear
  - a. Put on eye protection and adjust to fit
  - b. Face shield should fit over brow
5. Put on gloves
  - a. Put on gloves, taking care not to tear or puncture glove
  - b. If a gown is worn, the glove fits over the gown's cuff

### Taking off PPE

1. Remove Gloves
  - a. Remove gloves using a glove-to-glove/skin-to-skin technique
  - b. Grasp outside edge near the wrist and peel away, rolling the glove inside-out
  - c. Reach under the second glove and peel away
  - d. Discard immediately into waste receptacle
2. Remove Gown
  - a. Remove gown in a manner that prevents contamination of clothing or skin
  - b. Starting at the neck ties, the outer 'contaminated' side of the gown is pulled forward and turned inward, rolled off the arms into a bundle, then discarded immediately in a manner that minimizes air disturbance
3. Perform Hand Hygiene
4. Remove Eye Protection
  - a. Arms of goggle/headband of face shields are considered 'clean' and may be touched with the hands, the front of eye protection is considered contaminated
  - b. Remove eye protection by handling ear loops, sides or back only
  - c. Discard into waste receptacle or into appropriate container for reprocessing
5. Remove Mask/N95 Respirator
  - a. Ties/ear loops/straps are considered 'clean' and may be touched with hands
  - b. The front of the mask/respirator is considered to be contaminated
  - c. Untie bottom tie then top tie, or grasp straps or ear loops
  - d. Pull forward off the head, bending forward to allow mask/respirator to fall away from the face and discard into waste receptacle
6. Perform Hand Hygiene

## PUTTING 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



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## REMOVING PERSONAL PROTECTIVE EQUIPMENT

**1**

**REMOVE GLOVES**



**2**

**REMOVE GOWN**



**3**

**PERFORM HAND HYGIENE**



**4**

**REMOVE EYE PROTECTION**



**5**

**REMOVE MASK OR N95 RESPIRATOR**



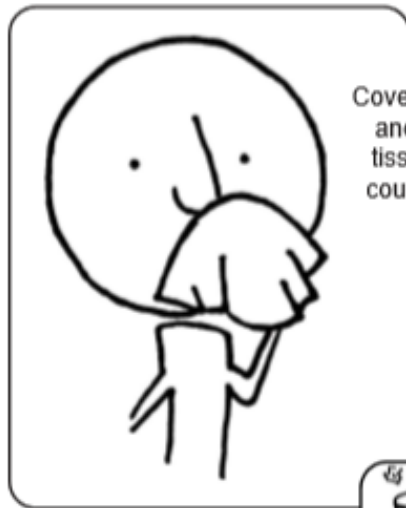
**6**

**PERFORM HAND HYGIENE**



Stop the spread of germs that make you and others sick!

# Cover your Cough



Cover your mouth and nose with a tissue when you cough or sneeze or cough or sneeze into your upper sleeve, not your hands.



cough or sneeze into your upper sleeve, not your hands.

Put your used tissue in the waste basket.



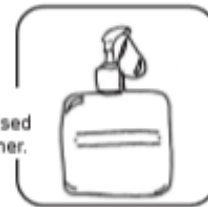
You may be asked to put on a surgical mask to protect others.

## Clean your Hands

after coughing or sneezing.



Wash with soap and water or clean with alcohol-based hand cleaner.





# Did You Wash Your Hands?



**1** Wet hands and apply soap



**2** Rub hands briskly for 15-20 seconds



**3** Rinse well



**4** Pat hands dry with paper towel



**5** Turn off water with paper towel and discard

**Protect Yourself  
Protect Your Family**



## APPENDIX H – CLEANING AND DISINFECTION IN COMMUNITY SHELTERS

### CLEANING OF BLOOD AND BODY FLUIDS CHECKLIST <sup>1, 10</sup>

- 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.
  
- Inspect the area around the spill for splatters and splashes that may have occurred outside of the main spill area
  
- Restrict the activity around the spill until area has been cleaned, disinfected and dried
  
- 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)
  
- Confine and contain the spill
  
- Wipe up any blood or body fluid spills immediately using disposable paper towels
  
- 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
  
- 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
  
- Wipe up the area again using disposable towels and discard into regular waste
  
- Take care to avoid splashing or generating aerosols during the clean up
  
- Remove PPE in the correct order and perform hand hygiene

## ROOM CLEANING AND DISINFECTING CHECKLIST <sup>1, 10</sup>

- Gather cleaning materials and supplies
- Perform hand hygiene and put on gloves
- Remove dirty linen:
  - Strip the bed, roll sheets carefully to prevent aerosols
  - Inspect bedside curtains and window treatments and if visibly soiled, clean or change
- Remove gloves and perform hand hygiene
- Apply clean gloves and clean the room working from clean to dirty areas and from high to low areas of the room
- If a bucket is used do not 'double-dip' cloths back into cleaning solution once used
- Change the cleaning cloth when it is no longer saturated with disinfectant and after cleaning heavily soiled areas
- If there is more than one client bed space in the room, use fresh cloths for each and complete the cleaning in each bed space before moving to the next
- Dust high places in the room
- Inspect window coverings and launder/wipe clean/vacuum if visibly soiled
- Clean door handles and touched areas of the door
- Check walls for visible soiling and clean if required
- Clean light switches, thermostats, wall mounted items, glass and mirrors
- Clean all furnishings and clean inside drawer
- Clean inside and outside of closet
- Clean the bed:
  - Check for cracks or holes in mattress and replace as required
  - Clean entire mattress and inspect for pests
  - Clean exposed platform and frame
  - Clean outside of bed including footboard, headboard and lower parts of the bed frame. Pay attention to areas that are visibly soiled and surfaces that are frequently touched
- Remove gloves and clean hands with ABHR; if hands are visibly soiled, wash with soap and water
- Do not leave room wearing soiled gloves
- Remake bed and replenish supplies as required
- Dispose of soiled linens, cleaning materials and waste
- Clean floors (see floor cleaning procedure)

## WASHROOM CLEANING AND DISINFECTING CHECKLIST <sup>1, 10</sup>

- Gather cleaning materials
- 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
- Perform hand hygiene and put on gloves
- Change cloths when they are no longer saturated with disinfectant or cleaning solutions and after cleaning heavily soiled areas
- It is important to clean from clean to dirty areas:
  1. Remove soiled linen from floor
  2. Wipe up spills
  3. Remove waste from the room
  4. Clean door handles and touched areas of the door
  5. Clean light switches, wall attachments and mirrors
  6. Clean all dispensers, frames, cabinets and shelves
  7. Clean railings, ledges, shelves and pipes
  8. Clean shower/tub faucets, walls and railings – scrub as required to remove soap scum
  9. Clean entire toilet including handles and underside of flush rim
- Dispose of waste
- Remove gloves and perform hand hygiene
- Replenish supplies in washroom (e.g. paper towel, soap, toilet paper, garbage bag, sanitizer)
- Clean floor (see floor cleaning checklist)

## FLOOR CLEANING CHECKLIST<sup>1, 10</sup>

### Step 1: Use a dry mop, clean from clean to dirty areas:

- Perform hand hygiene and put on gloves
- 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 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 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 being mopped
- Perform hand hygiene and put on gloves
- Dip mop in cleaning solution and wring out
- Mop from clean to dirty area (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 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

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

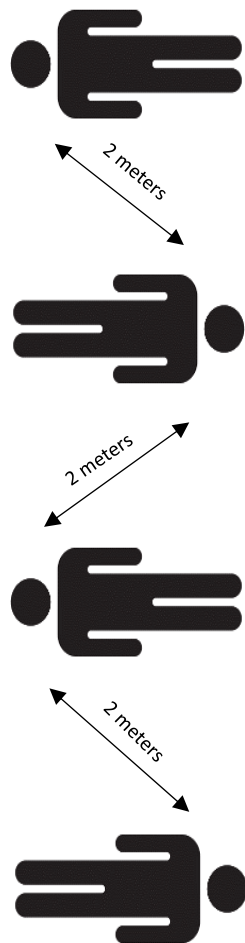
- Prepare cleaning solution as per manufacturer's instructions
- Place 'wet floor' caution sign outside of room being mopped
- Attach microfiber pad to mop head frame
- Perform hand hygiene and put on gloves
- Soak microfiber pads with cleaning solution
- Remove a soaked microfiber pad, wring out and attach to mop
- Mop clean to dirty areas
- Replace microfiber pad when soiled and use a fresh microfiber pad for each room
- Remove gloves and perform hand hygiene

**APPENDIX I – BED SPACING** <sup>12, 13</sup>

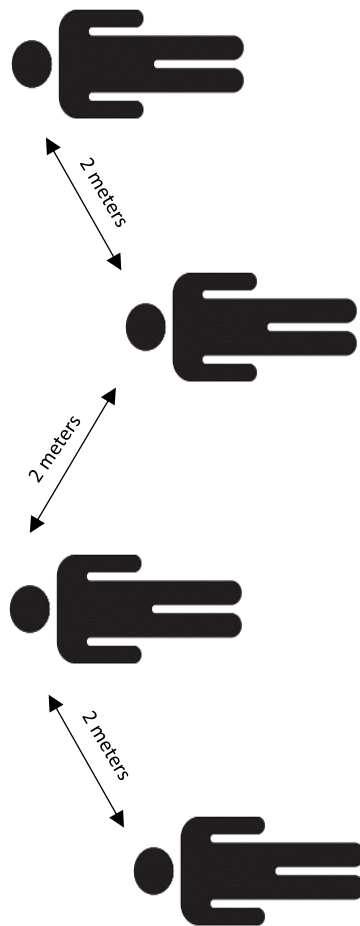
As germs in respiratory droplets (e.g., coughing and sneezing) can spread up to two meters, aim for beds to be spaced so that there is a separation of two meters between clients, to decrease the risk of spreading germs.

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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