



# **GROUP HOMES INFECTION PREVENTION AND CONTROL RESOURCE MANUAL**

**NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT**

**JULY 2022**

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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 resident, changing clothes, continence care, dressing changes, care of open wounds/lesions, toileting).<sup>12</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 Resident:** The immediate space around a resident that may be touched by the resident and may also be touched by the health care provider when providing care. The resident 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 resident uses. In a multi-bedroom, the resident environment is the area inside the individual's curtain.<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. ABHR is only effective if used when hands are not visibly soiled.<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 residents, 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, mirrors and floors).<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 residents during all care to prevent and control transmission of microorganisms in group home settings.<sup>10</sup>

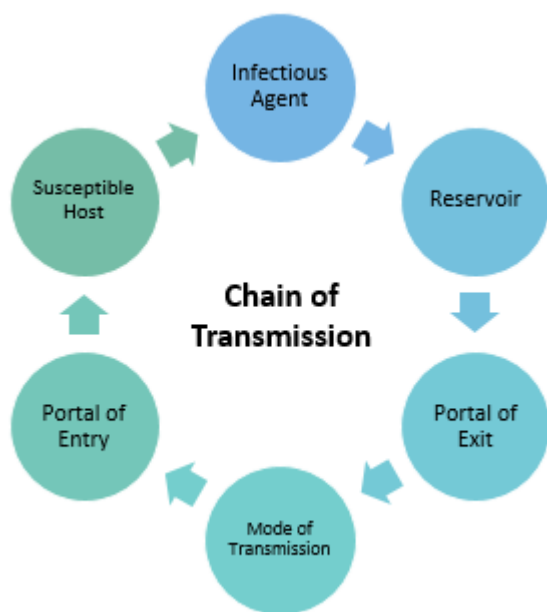
## INTRODUCTION



Infection prevention and control is the key to promoting healthy people and a healthy environment. Group home staff have the responsibility of maintaining a healthy environment for their residents. The intent of this guide is to inform and educate group home staff on current recommendations for infection prevention and control measures, to reduce the risk of transmission of microorganisms in group home 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 (e.g. breathing it in, contact with mucous membranes, eating or drinking contaminated food or water, or 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, 12</sup>

One of the most effective preventive measures to protect residents and staff from acquiring communicable diseases is immunization. It is important to stay up to date on all publicly funded vaccinations. Appropriate vaccines for susceptible health care providers include:

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

Resident immunization status should be assessed upon admission to the home and annually thereafter. For further information regarding immunizations contact the Vaccine Preventable Diseases Department, see [Appendix A](#).



## ROUTINE PRACTICES <sup>12</sup>

Routine practices refer to infection prevention and control practices used with all residents 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 resident 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 resident 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 resident.

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 residents 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 resident to staff, staff to resident, resident to resident 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 resident. 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.

## ADDITIONAL PRECAUTIONS <sup>12</sup>

Additional Precautions refer to infection prevention and control measures that are used in addition to Routine Practices to protect staff and residents by interrupting transmission of suspected or identified infectious agents. Measures may include PPE, additional environmental cleaning or private accommodation. Additional Precautions must be implemented as soon as a transmissible infection is suspected, not only when a diagnosis is confirmed; for example, when diarrhea in a resident is detected.

There are three categories of Additional Precautions: Contact Precautions, Droplet Precautions and Airborne Precautions.

## CONTACT PRECAUTIONS

Contact transmission is the most common route of transmission of infectious agents. There are two types of contact transmission: direct and indirect.

Direct contact occurs through touching; for example, an individual may transmit microorganisms to others by touching them.



Indirect contact occurs when microorganisms are transferred via contaminated objects; for example, *C. difficile* might be transferred between residents if a commode used by an infected resident is taken to another resident without cleaning and disinfecting the commode in between uses.



In residential settings, placement of residents requiring Contact Precautions should be reviewed on a case-by-case basis. Infection risk to other occupants of the room must be considered when selecting roommates.

Gloves and gown are required for activities that involve direct care with the resident or the resident's environment. Gloves and gown, if worn, must be removed and hands cleaned immediately following the activity for which they were used. It is never appropriate for residents to wear gloves or isolation gowns while outside their room. Always ensure hand hygiene by the resident on leaving his/her room.



Routine cleaning practices are acceptable for most rooms on Additional Precautions. Residents with *C. difficile* or other antibiotic-resistant organisms may require additional environmental cleaning and transportation procedures.

Visitors should be given education regarding hand hygiene. PPE is not required unless the visitor is providing direct care.

### **DROPLET PRECAUTIONS**

Droplet Precautions are used in addition to Routine Practices for residents known or suspected of having an infection that can be transmitted by large respiratory droplets (e.g. influenza, whooping cough and the common cold).

Droplet transmission occurs when droplets carrying an infectious agent exit the respiratory tract of a person. These droplets can be generated when a person talks, coughs, or sneezes. These droplets travel up to two metres or more and may enter the eyes, nose or mouth of someone nearby or fall onto and contaminate surfaces.

Ideally, residents requiring droplet precautions should be placed in private rooms. If a private room is not available, maintain a spatial separation of at least two metres from other residents.

A mask and eye protection must be worn by any individual who is within two metres of the resident on Droplet Precautions.



In most cases, residents should remain at home if ill unless required for diagnostic or medical appointments. The resident must wear a mask during transport, if tolerated. If the resident cannot tolerate wearing a mask, then staff should wear a mask and eye protection.

Visitors should receive education regarding hand hygiene. A mask should be worn by visitors within two metres of the resident.

### **AIRBORNE PRECAUTIONS**

Airborne Precautions are used in addition to Routine Practices for residents known or suspected of having an illness that is transmitted by the airborne route. Examples include tuberculosis, varicella (chicken pox) and measles. In most cases, residents requiring airborne precautions will remain in the hospital. See [Appendix A: How to Reach Us](#) for further guidance on Additional Precautions.

## 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 group home setting, the role of environmental cleaning is important because it reduces the number and amount of infectious agents that may be present and may also 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 residents 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.

Residents 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 resident. In general, the resident environment includes the resident's individual environment (e.g., bed space/bedroom, bathroom) and personal mobility devices (e.g., wheelchair, walker) and may include shared spaces such as group rooms, dining areas, central showers and washrooms.

Some items in the resident'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 resident 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 group home setting include: beds and linens, furniture, door handles, computer keyboards, telephones, thermometers, faucets, light switches, bathrooms, pens, sinks and televisions.

**High-touch surfaces** in the immediate vicinity of a resident may be a reservoir for pathogens. The hands of residents and staff transmit these pathogens directly or indirectly. It is

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

See [Appendix 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 and disinfect should wear PPE:

- For protection from microorganisms
- For protection from chemicals used in cleaning
- To prevent transmission of microorganisms from one resident 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 resident environment and before contact with another resident environment.

- Perform hand hygiene after removing gloves.



## ADMINISTRATION'S ROLE IN CLEANING AND DISINFECTION

Group homes 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

Group homes must have policies and procedures that ensure that:

- Cleaning is a continuous event in the home
- 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 group home 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, e.g., an outbreak of *C. difficile* would require the use of a disinfectant with a sporicide.

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

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, procedures and schedules for cleaning and disinfection.

## ANTIBIOTIC RESISTANT ORGANISMS (AROS) <sup>10, 11</sup>

AROs are certain bacteria that do not respond to antibiotics, making the infections they cause harder to treat. This can result in increased illness and mortality to those who are vulnerable.

ARO's include the following organisms:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Vancomycin-resistant Enterococcus (VRE)
- Resistant Enterobacteriaceae including
  - Carbapenemase-Producing *Enterobacteriaceae* (CPE)
  - Extended-Spectrum Beta-Lactamase (ESBL)

The good news is that infection control practices, such as hand hygiene and preventing cross-contamination in your group setting, can reduce the transmission of these organisms between the residents and staff of the group home.



### 1. Consistent use of Routine Practices with all residents.

Hand hygiene should occur:

- Before resident or environment contact
- Before doing any procedure (e.g. dressing change)
- After any care involving body fluids
- After all resident or environment contact

### 2. Screening of all AROs will help prevent and control the spread of them. Consider admission screening and reviewing client information after each hospitalization. For detailed information regarding screening, testing and surveillance of AROs please see the Provincial Infectious Diseases Advisory Committee Document, [Annex A: Screening, Testing and Surveillance for Antibiotic-Resistant Organisms \(AROs\) in All Health Care Settings](#)



3. Initiate Contact Precautions for anyone with a known ARO:

- Appropriate room
- Gloves for all direct care activities
- Dedicated equipment or adequate cleaning and disinfecting of shared equipment
- Cleaning for MRSA, CPE and ESBL: perform regular cleaning while paying special attention to bathrooms and to high-touch surfaces such as light switches and door knobs
- Cleaning for VRE: perform regular cleaning while paying special attention to bathrooms and to high-touch surfaces. Consider cleaning twice daily. A low-level hard surface disinfectant should be used. Freshen cleaning supplies frequently to avoid cross-contamination, do not “double dip” cleaning cloths.
- Notify your Infection Prevention & Control representative or supervisor to discuss the management of the resident

## 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 a 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>13</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 group homes 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, group homes provide a favorable environment for illness to spread. An outbreak is suspected when there are a greater than expected number of ill residents (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 residents 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 resident 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 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).

## SURVEILLANCE

Surveillance means assessing residents 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 residents and staff and the consistent use of Routine Practices.

If there is an increase or an unexpected amount of illness in the home, implement **Additional Precautions** based on the illness. If 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 residents in the home (e.g., how many are ill, what their symptoms are, when they started, and how many are living in the home) in order to confirm whether an outbreak is occurring.

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, residents, families 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](#) 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 residents who recover, any residents 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 (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

### TB SCREENING RECOMMENDATIONS FOR GROUP HOME RESIDENTS

The Canadian Tuberculosis Standards, 7<sup>th</sup> edition (2014) recommends the following in order to screen residents for TB disease prior to admission to a group home:

1. **Medical Assessment:** For all residents, a physical assessment and symptom review by a physician/nurse practitioner, to rule out active pulmonary TB, should be completed on admission. If symptoms are present, a chest x-ray is recommended regardless of the resident's age. If signs and symptoms and/or chest x-ray results indicate potential active pulmonary disease, the resident should be transferred to an appropriate medical facility until active tuberculosis is ruled out or until the resident is no longer infectious.
2. **Chest x-ray:** For residents over 65 years of age, a chest x-ray (posterior-anterior and lateral) should be taken upon admission to the home.



3. **Tuberculin Skin Test (TST):** For residents 65 years of age and younger, who are previously skin test negative or unknown, a 2-step TST is recommended. If the resident has a previously documented 2-step, only a one-step TST is necessary. A TST is not recommended for residents who have had a previous positive TST result. For residents with a previous positive TST result, the most current result should be recorded in millimeters (mm) including the date the TST was administered and read.



4. **Transfers:** Prior to transfer from another facility, a physical assessment and symptom review of the resident, by a physician/nurse practitioner to rule out active pulmonary TB is recommended. In addition, the chest x-ray previously done upon admission or any more recent radiology should be reviewed. If there is any indication of possible active TB, a repeat chest x-ray, sputum testing and any other necessary investigations should be done to rule out active pulmonary TB disease before the resident is transferred.

### TB SCREENING RECOMMENDATIONS FOR EMPLOYEES AND VOLUNTEERS

TB screening is recommended upon initial hire or placement at the facility, 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.   | If both tests are negative, annual TST is not recommended<br>If either TST is positive refer to *Person with a positive TST |
| Person with documented results of previous 1-step TST | If test was negative and done >12 months ago, a 2-step TST is necessary<br>If test was negative and done <12 months ago, a 1-step TST is required<br>If test was positive see section *Person with a positive TST | If tests are negative annual TST is not recommended<br>If either test is positive refer to *Person with a positive TST      |
| Person with documented results of previous 2-step TST | If both tests were negative and done >12 months ago, a 1-step TST is necessary<br>If both tests were negative and done <12 months ago, no further testing is recommended  | If both tests are negative annual TST is not recommended<br>If either test is positive refer to *Person with a positive TST |

\*Person with a positive TST

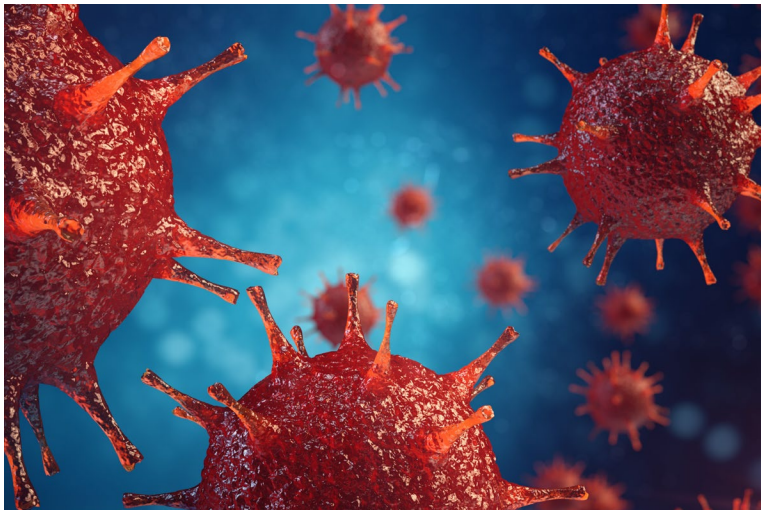
|  |   |
|--|---|
| <p>Refer to Health Care Provider for a further assessment (symptom review and a chest x-ray are recommended to rule out active TB disease)</p> <p>Further skin testing is not recommended</p> <p>The person should be informed of the signs and symptoms of active TB disease and advised 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> |
|--|---|

Annual TB skin testing for employees and volunteers is not recommended  
 Note: Persons with medical conditions severely weakening the immune system may have a negative TST even though they have TB infection

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

According to the Health Protection and Promotion act, “supported group living residences which are defined under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* to mean a staff-supported residence operated by a service agency, in which three or more persons with developmental disabilities reside and receive services and supports from the agency; “shall report to the medical officer of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease. R.S.O. 1990, c.H.7, s.27 (2).

This reporting would include notifying the North Bay Parry Sound District Health Unit (NBPSDHU) of any known or suspect TB cases. The Diseases of Public Health Significance Notification Form as well as information about diseases of public health signification 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:<br>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 use 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: 704-474-1400 ext. 5328</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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## APPENDIX D - STEPS FOR PUTTING ON AND TAKING OFF PERSONAL PROTECTIVE EQUIPMENT<sup>12</sup>

### 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. Shape 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 head, bend forward allowing mask/respirator to fall from face
  - e. Discard immediately 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



Public  
Health  
Ontario

PARTNERS FOR HEALTH

Santé  
publique  
Ontario

PARTENAIRES POUR LA SANTÉ

[www.oahpp.ca](http://www.oahpp.ca)

## REMOVING PERSONAL PROTECTIVE EQUIPMENT

**1**

**REMOVE GLOVES**



**2**

**REMOVE GOWN**



**3**

**PERFORM HAND HYGIENE**



**4**

**REMOVE EYE PROTECTION**



**5**

**REMOVE MASK OR N95 RESPIRATOR**



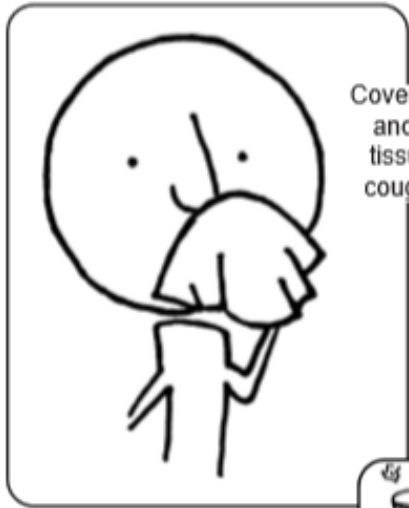
**6**

**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.



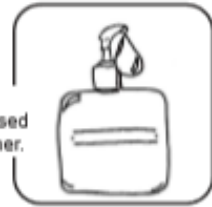
You may be asked to put on a surgical mask to protect others.

## 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 G – CLEANING AND DISINFECTION IN GROUP HOMES

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

- Assemble materials required for dealing with the spill. Materials needed:
  - Disposable paper towels
  - PPE (gloves, gown, facial protection, mask or face shield)
  - Regular waste 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 resident 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 drawers
- 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 instructions. 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 areas (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 by 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 microfiber 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

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