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FREQUENTLY ASKED QUESTIONS

COVID-19: Congregate Living Settings

07/10/2020

The original version of this document was posted on June 18, 2020. The current version contains additional sections as follows: Mask Use, Personal Protective Equipment (PPE), Prevention and preparedness, Resident placement/isolation, Return to work and Screening, Staffing, Support, Testing, Worker placement/isolation.

Introduction

These frequently asked questions and answers are intended to support administrators and staff members in a range of congregate living settings (e.g., shelters, group homes, supportive housing). Many of the questions were received from congregate living settings webinars[1] delivered in May 2020, as well as from other sources. Although not specific for correctional facilities, some of the responses may be applicable to these settings. This document is not intended for use in long-term care and retirement homes.

This document will be updated periodically as answers to additional questions are received, answers are revised or new resources become available. The date the answer was drafted is indicated and a revision date will be added beside any updated answers.

This document should be used in addition to – but does not replace – the advice, guidance, recommendations, directives or other direction of provincial Ministries and local public health units. See the Ministry of Health's COVID-19 Guidance: Congregate Living for Vulnerable Populations.[2] Additional resources for congregate living settings can be found on Public Health Ontario's website.[3]

Contents

General

This chapter addresses general questions on COVID-19.

Q1. Can droplets from coughs travel further than 2 metres?

Written May 24, 2020

Large droplets from coughing or sneezing generally fall to the floor or surfaces within 2 metres[4] of the coughing or sneezing individual although it may be possible for some smaller droplets to travel further. To ensure coughs and sneezes do not infect others, it is important to block the droplets. Therefore it is recommended to cough and sneeze[5] into a tissue or your sleeve or elbow, and clean your hands afterwards[6]. Wearing a mask[7] (non-medical or surgical/procedure mask) will also help trap large droplets from the mouth or nose during coughing, sneezing, talking or singing (referred to as source control, where the goal is protecting others).

Q2. Can the same individual be infected with COVID-19 more than once?

Written May 24, 2020

To date, there is no well-documented evidence[8] of people becoming infected more than once. However, it is still uncertain if a past infection provides protection against future infections. Although it appears that most people who have been infected develop antibodies (substances the body makes to protect against future infection as a result of past infection or vaccination), it is currently uncertain if these antibodies will protect against future infection. If the antibodies do protect against future infection, it is uncertain how long that protection will last. Further research will help to answer these questions.

Q3. Can an individual who has been infected with COVID-19 continue to be a carrier of infection and transmit illness to others?

Written May 24, 2020

To date, there is currently no indication[9] of people being carriers of COVID-19. The exact length of time someone is infectious with COVID-19 is not known for certain. A few studies suggest that people are no longer infectious after 7[10] or 8[11] days from the start of their symptoms. After that time it is still possible to find parts of the virus (the genetic material, RNA) in the nose and throat of some people; RNA has been found up to 3 to 4 weeks[9] after the first symptom started or sometimes longer. However, there is no evidence that people can spread their infection to others for that long. Ontario guidelines[12] indicate that infected people with symptoms should generally remain separate from others (isolated) for 14 days after they first developed symptoms. After that they are considered no longer infectious, as long as they have no fever and their symptoms have been improving for at least 72 hours.

Q4. How likely is it for someone to be exposed to COVID-19 after entering a space once an individual who is a confirmed case of COVID-19 has left the space?

Written May 24, 2020

COVID-19 spreads by droplets from an infected person that can land in the mouth, nose or eyes of another person. The infected person can release droplets from their mouth and/or nose when they cough, sneeze, sing, speak or breathe. Nearby surfaces and objects can become contaminated by droplets that fall on them, or if an infected person touches the surfaces or objects when they have virus on their hands.

If the virus has landed on surfaces that have not been properly cleaned and disinfected, this is a possible way to be exposed. Surfaces and objects with the virus will not look dirty. Spread from surfaces

contaminated with the virus may occur if someone touches them and then touches their mouth, nose or eyes without cleaning their hands. There is very little information[4] about spread from surfaces at this time.

There is currently no evidence of spread of COVID-19 after breathing air in a room after an infected person has left the room.

Q5. How long can COVID-19 survive on different surfaces?

Written May 24, 2020

There is very little information[4] about how long COVID-19 can survive on surfaces at this time. One experiment[13] found that the virus can live for up to 72 hours, depending on the type of surface it was on. The experiment found that the virus fell to low or non-existent levels after 72 hours on plastic, 48 hours on stainless steel, 24 hours on cardboard and 4 hours on copper.

Q6. Does warm water need to be available for hand washing or is cold water sufficient?

Written May 24, 2020

Either warm or cold water[14] can be used to wash hands. It is easier to create lather with warm water and the person may prefer warm water over cold water. Liquid soap should be used instead of bar soap as bar soap can become contaminated with germs.

Admission/Re-admission

This chapter addresses questions on admission and re-admission of residents.

Q1. What processes need to be followed when a new resident is admitted from the community or from another facility (screening, testing, isolation etc.)?

Written May 24, 2020

Consult the Ministry of Health COVID-19 Guidance: Congregate Living for Vulnerable Populations.[2] All new admissions should be screened for symptoms of COVID-19[15] prior to admission. Screening may be conducted over the phone prior to the resident arriving on site (preferred, where possible), or may be conducted upon the resident's arrival at the facility.

- For settings where residents are **expected to stay more than 14 days (long stay settings)**, residents should be tested for COVID-19 before admission if possible. The facility will need to decide how they will manage residents who test positive. : It is important not to delay admissions if that will affect resident safety.

- Regardless of the test results, all new admissions to long stay settings should stay separated (isolated) from other residents for 14 days. Isolation is best done in a private room with a private bathroom and with meals provided in the room if possible. Residents should wear a non-medical mask if they may be near others (unless they are ill when they should wear a surgical/procedure mask), if tolerated, and be encouraged to frequently clean their hands.[6] Staff members providing direct care or service (within 2 metres/6 feet) for these residents should wear a surgical/procedure mask, eye protection, gown and gloves. Personal protective equipment should be removed properly[16] and hands cleaned.[6]

- For facilities where residents are **expected to stay less than 14 days (short stay settings)**, residents should be screened for symptoms of COVID-19[15] before arrival (if possible) and on arrival at the facility.

Q2. What processes need to be followed when a resident returns to the facility (e.g. following travel, a hospital stay, ER/healthcare provider appointment or after visiting family)?

Written May 24, 2020; Updated June 24, 2020

- Anyone entering the facility should be screened for symptoms of COVID-19[15] and residents should be monitored twice daily.

- **Residents with COVID-19** returning to the facility from hospital should remain separated from others (isolated) or grouped with other COVID-19 positive residents until cleared as per Ministry of Health criteria.[12]

- **Residents who are not known to have COVID-19** who are returning from overnight stays away from the facility should be treated like a new admission (see Admissions/Readmissions Q1 above).

- Residents who are returning to the facility **after a same day appointment or other off-site visit** (no overnight stay away from the facility) generally would not need special measures. The following precautions should be taken:

    - If possible, when going to offsite appointments or visits that may require being near other people, residents should wear a non-medical mask[7] when in transit and at the appointments or visits and whoever they are seeing should also wear a mask.

- Residents should try not to touch surfaces and objects while out of the facility. They should try to pay for anything they buy without touching surfaces or objects, if possible.

- Residents should clean their hands[6] frequently, particularly after touching surfaces touched by others and upon return to the facility. They should avoid touching their face.

- As much as possible, residents should remain at least 2 metres apart from anyone they are seeing in the community.

- Follow provincial requirements/recommendation[17] regarding types of visits that are permitted within the facility and for visiting with others outside the facility.

- Monitoring of residents for symptom of COVID-19[15] should be conducted twice daily as per usual practice.

Q3. How can staff facilitate the move-in of a new resident and their belongings in a safe manner?

Written May 24, 2020

- Residents who are being admitted to the facility where their **stay is expected to be 14 days or longer (long stay settings)** are to be separated from others (isolated), preferably in a private room with a private bathroom. They should wear a non-medical mask if they may be near others, if tolerated (unless they are ill when they should wear a surgical/procedure mask). Their belonging should be moved directly to their room. Because new resident to long stay settings are being isolated, staff members providing their direct care or service (within 2 metres (6 feet)) should wear a surgical/procedure mask, eye protection, gown and gloves; this would include when moving in their belongings. Hands should be cleaned[6] after gloves are removed.

- **New residents admitted to facilities where the stay is expected to be less than 14 days (short stay settings)** do not require isolation. Hands should be cleaned after touching resident's belongings. All staff members should be wearing a mask (surgical/procedure or non-medical depending on the circumstances[2]) at all times and residents should be offered a non-medical mask to wear if they need to be in common areas where physical distancing[18] (staying more than 2 metres (6 feet) apart) may be difficult to maintain.

See Q1 in the Admission/Re-admission section for additional information on screening and testing.

Q4. When can a facility consider accepting new admissions and when should these be put on hold?

Written May 24, 2020

- As per the Ministry of Health's COVID-19 Guidance: Congregate Living for Vulnerable Populations,[2] for settings where residents are **expected to stay more than 14 days (long stay settings)**, residents should be tested for COVID-19 before admission if possible. In deciding whether to accept a resident with a positive test result or whose test results are not yet available, the facility will need to consider their ability to isolate the resident. COVID-19 positive new admissions would require isolation in a private room or can be grouped with other residents who are positive for COVID-19. : It is important not to delay admission if a delay will affect resident safety.

- **During an outbreak of COVID-19 in the facility**, COVID-19 positive residents who were admitted to hospital can be accepted back to the facility and can share rooms with other COVID-19

positive residents until they are considered resolved and isolation is no longer required.[12] As per the Ministry of Health's COVID-19 Guidance: Congregate Living for Vulnerable Populations,[2] it is best practice not to admit residents who are not known to be COVID-19 positive to an outbreak area. Your public health unit will advise about admissions during an outbreak.

- If a new resident has symptoms of COVID-19 based on screening upon entering the facility, they should be separated from others in a private room until a decision is made on how to arrange testing for the resident and where they will stay. If a private room is not available, the resident should wear a surgical/procedure mask and stay at least 2 metres from others. Ensure the resident cleans their hands.

Q5. How can a new resident be admitted safely if a facility does not have private rooms to facilitate isolation following admission?

Written May 24, 2020

Regardless of the test results, all new admissions to settings where the stay is expected to be 14 days or longer (long stay settings) should **stay separated (isolated)** from other residents for 14 days. Isolation is best done in a private room with a private bathroom and with meals provided in the room if possible. Residents should wear a non-medical mask if they may be near others (unless they are ill when they should wear a surgical/procedure mask), if tolerated, and be encouraged to frequently clean their hands.[6] Staff members should provide direct care or service (within 2 metres / 6 feet) to these residents while wearing[19] a surgical/procedure mask, eye protection, gown and gloves. Hands should be cleaned[6] after gloves are removed.

If a private room is not available for new long stay residents on admission, the resident should be placed in the largest room available with as few other residents as possible. The other residents in the room should not be at high risk for severe COVID-19 (i.e., the other residents should not be older adults or have underlying medical conditions). The new resident should be at least 2 metres (6 feet) from other residents with a partition between their beds. The new resident should be encouraged to wear a non-medical mask when they may be near others and to clean their hands[6] frequently. Meals should be provide in their room if possible or they should eat separately or at least 2 metres apart from other residents. They should avoid using a shared bathroom when others are in the bathroom. If bathrooms must be shared, see Q6 in the Infection Prevention and Control section.

Communication

This chapter addresses communication and advice to residents.

Q1. How can clients/resident/tenants be encouraged to follow physical distancing and other personal protective measures?

Written May 24, 2020

Facility staff are encouraged to maintain frequent communication with residents regarding COVID-19, actions being taken to prevent of COVID-19 within the facility and community, and the actions requested to be taken by residents.

Education and training can be provided and signs can be posted regarding the following:

- Respiratory etiquette[5] – coughing and sneezing into a tissue or into your elbow or sleeve, followed by cleaning your hands.
- Frequently cleaning your hands[6]. Hands should be cleaned:
    - upon entering the facility
    - before and after touching surfaces or using common areas or equipment
    - before eating
    - before and after preparing food
    - before putting on and before and after taking off a mask
    - before touching the face (including before smoking)
    - after using the bathroom
    - when dirty.
- Physical distancing[18]
- COVID-19 symptoms[15]

Methods to support physical distancing include:

- Discontinue activities that require close contact, including group in-person meetings.
- Stagger schedules for using common areas, shared kitchens, shared bathrooms and dining areas for meals, so that smaller groups of people use these areas, each at different times.
- Move furniture to encourage keeping a 2 metre (6 foot) distance apart and use tape on the floor to indicate where furniture should stay. Tables and chairs should be as far apart as possible (at least 2 metres/6 feet apart). Chairs should be set up so that residents are not directly facing each other. Block off or remove every other seat. Mark the floor with the locations where the seats should stay.
- Mark the floors with tape every 2 metres to increase spacing for residents standing in lines for meals or other services.

Q2. What measures can be taken to allow residents to remain socially connected while following physical distancing?

Written May 24, 2020

- If possible, provide access to phones, computers or tablets. Residents are encouraged to clean their hands before and after using any equipment.
- Shared equipment should be cleaned and disinfected after use by each person (using products that are safe for electronic equipment). If phones are shared and cannot be appropriately disinfected between use, cover them with a new disposable plastic bag for each use.
- Consider if the layout of the facility allows for some group activities to continue while maintaining physical distancing (2 metres/6 feet apart) between residents. Consider activities with residents sitting in their doorways or otherwise spaced 2 metres (6 feet) such as doorway dinners, trivia, music, or Bingo.

Q3. What personal protective equipment (PPE) advice can be given to clients residing in congregate living settings?

Written May 24, 2020

When there is no known COVID-19 in the facility:

- Residents should be encouraged to maintain physical distancing (2 metres/6 feet) from others (both within and outside of the facility) wherever possible. Visits and contact with others outside the facility should be minimized if possible.
- Residents should be provided with a non-medical mask[7] to use, if tolerated, when they may be near other people; this will protect others in the facility (source control to protect people around them from being exposed to virus when they talk, sing, cough, sneeze or breathe).
- Masks are not recommended for residents under 2 years of age or for residents of any age who are not able to remove their own mask or who has trouble breathing. See the Public Health Agency of Canada's guidance on Appropriate use of non-medical mask or face covering.[20]
- Residents should be reminded to avoid sharing food, drinks, smoking/drug supplies and personal hygiene items. Label personal hygiene equipment (e.g., toothbrushes, razors, combs) with the resident's name and do not leave these items or towels in common areas where they may be accidentally used by others.
- See Q1 in the Communications section for information on respiratory etiquette, cleaning hands and physical distancing.

Q4. What information should be provided to residents/clients who demand PPE for their own safety?

Written May 24, 2020

When there is no known COVID-19 in the facility:

- Residents may be encouraged to wear a non-medical mask[7] for source control (to protect people around them from being exposed to virus when they talk, sing, cough or sneeze), if tolerated. If residents choose to wear a cloth mask, they should be provided with information on how to use it properly.

- Personal protective equipment (PPE) may include surgical/procedure masks, eye protection, gowns and gloves. PPE is used by those who are involved in the provision of direct care or service to residents. The choice of PPE is dependent on the type of activities being provided[21] and the health status of the residents.

Education

This chapter addresses education and training for staff.

Q1. How should frontline employees be trained to properly select and use personal protective equipment (PPE)?

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The following resources are available on the appropriate use of PPE:

- How to put on[22] and take off[23] PPE videos
- Putting on and taking off PPE poster[24]
- Droplet and Contact Precautions in non-acute care facilities[19]
- Risk Algorithm to Guide PPE Use[21]

Some of the resources are summarized in At a Glance: Infection Prevention and Control Fundamentals.[25]

Environmental Cleaning

This chapter addresses cleaning and disinfection.

Q1. How and how often should shared workspaces and communal items (e.g., telephones) be cleaned and disinfected?

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- Shared workspaces are to be cleaned and disinfected[26] between uses by different individuals. If workspaces are shared it is recommended that a log be kept to document when cleaning was performed and by whom.
- Shared items that are made of hard materials should be cleaned and disinfected[26] between uses by different individuals, e.g., remote controls, telephones, toys. Shared items that cannot be cleaned, such as puzzles, cards, and stuffed animals, should be removed or purchased new and used only by a single resident.
- Shared electronic equipment should be cleaned and disinfected[26] after use by each person (using products that are safe for electronic equipment). If phones are shared and cannot be appropriately disinfected between uses, cover them with a new disposable plastic bag for each use.
- Residents are encouraged to clean their hands before and after using any shared equipment or workplaces.
- Commonly used cleaners and disinfectants are effective against COVID-19. Disinfectants should have a Drug Identification Number (DIN; 8-digit number) given by Health Canada. They should ideally work quickly (e.g., only need to remain on surfaces for 5 minutes or less to kill germs).

Q2. How often should environmental cleaning take place for various surfaces and areas of the facility/home, including communal kitchens, washrooms, lounge areas, and high-touch surfaces?

Written May 24, 2020

- Clean and disinfect[26] frequently touched surfaces and objects **at least twice a day** and when they look dirty. Examples of frequently touched objects include: doorknobs, elevator buttons, light switches, counters, hand rails, touch screen surfaces, keypads and table tops.
- Shared kitchens and shared bathrooms should be cleaned and disinfected at least twice daily and when dirty. If groups are taking turns using the kitchen or bathroom on a staggered basis, the kitchen and bathroom should be cleaned and disinfected after each group.
- Table tops and arms of chairs should be cleaned and disinfected after each meal and when dirty. If groups are taking turns using the dining room on a staggered basis, table tops and the arms of chairs should be cleaned and disinfected after each group.
- Other surfaces[27] that are less commonly touched are to be cleaned and disinfected on a regular schedule depending on how frequently they are touched. Floors should be cleaned on a regular schedule and when visibly dirty. Walls should be cleaned when visibility dirty.
- Commonly used cleaners and disinfectants are effective against COVID-19. Disinfectants should have a Drug Identification Number (DIN; 8-digit number) given by Health Canada. They should ideally work quickly (e.g., only need to remain on surfaces for 5 minutes or less to kill germs).

Q3. Are there any situations where cleaning/disinfection is recommended to be conducted by an outside cleaning company?

Written May 24, 2020

Facilities may choose to involve an outside cleaning company if the facility is not able to keep up with routine cleaning and disinfection.

Q4. What options exist for cleaning and disinfection when disinfecting products (e.g., disinfectant wipes) are difficult to obtain?

Written May 24, 2020

Commonly used cleaners and disinfectants are effective against COVID-19. Disinfectants should have a Drug Identification Number (DIN; 8-digit number) given by Health Canada. They should ideally work quickly (e.g., only need to remain on surfaces for 5 minutes or less to kill germs).

Bleach may be considered for use as a disinfectant when commercially prepared disinfectant products are in short supply. (See Q5 in Environmental Cleaning section).

Q5. What is the appropriate dilution of bleach and water, if household bleach is used as a disinfectant?

Written May 24, 2020

A 1:500[28] (100 parts per million) dilution of household bleach (5.25% sodium hypochlorite) and water left on the surface to air dry is sufficient for disinfecting food contact surfaces (e.g., countertops, dining tables). A 1:100[28] (500 parts per million) dilution of bleach and water left on the surface for five minutes is sufficient for disinfection of most other surfaces (e.g., chairs, tables). the bleach solution are to be replaced daily in order to be effective. Public Health Ontario has an online chlorine dilution calculator[29] that can help to determine how much bleach and water are needed to reach the desired concentration.

Q6. How should cleaning be performed once a COVID-19 positive individual has been discharged from the facility or at the end of their isolation period?

Written May 24, 2020

- Staff should wear[24] a surgical/procedure mask, eye protection, gown and gloves when cleaning the room where a resident had COVID-19 but has now left the room or has been cleared of their infection[12] (infection has resolved and resident no longer requires isolation).
- All surfaces, including high-touch surfaces are to be cleaned and disinfected[26] using your usual cleaning products.
- Ensure the use of the appropriate products and that the product remains on surfaces for the appropriate time (contact time). Commonly used cleaners and disinfectants are effective against COVID-19. Disinfectants should have a Drug Identification Number (DIN; 8-digit number) given by Health Canada. They should ideally work quickly (e.g., only need to remain on surfaces for 5 minutes or less to kill germs).
- Clean and disinfect moving from “clean to dirty” areas, meaning start with the parts of the room that are the least likely to have virus (e.g., those furthest from the resident’s bed and/or least

likely to have been touched) and move towards those that are most likely to have virus. The lasts places to clean are the high-touch surfaces in the room (e.g., doorknobs, light switches), followed by the resident's bed, followed by the bathroom.

- Clean and disinfect the mattress if possible. Throw out any remaining toilet paper and the toilet brush. Launder all bedding with soap and the hottest setting available and dry thoroughly.

Q7. How should environmental cleaning be managed in the facility if an ill resident/client refuses or is unable to self-isolate?

Written May 24, 2020

- If an ill resident refuses or is unable to self-isolate, places they sit and, if possible, objects they touched should be cleaned and disinfected afterwards.
- Ensure frequently touched surfaces and objects are cleaned and disinfected[26] at least twice a day and when they look dirty. Examples of frequently touched objects include: doorknobs, elevator buttons, light switches, counters, hand rails, touch screen surfaces, keypads and table tops.
- Remove items that are difficult to clean such as puzzles, cards, and stuffed animals.

Food Safety

This chapter addresses food and food safety-related questions.

Q1. Do incoming deliveries of food and other supplies need to be sanitized/disinfected upon entry to the facility?

Written May 24, 2020

- Do not use cleaning products (sanitizers or disinfectants) or soap directly on food.
- Deliveries should be dropped off at the door, if possible, so the delivery person does not need to enter the facility.
- Packaging should be thrown out and any surfaces they touched should be cleaned and disinfected.[26]
- After handling deliveries and using sanitizer/disinfectant, hands should be cleaned.[6]

Q2. How should kitchen and dining areas be managed within a home/facility to minimize the potential for spread of infection?

Written May 24, 2020

- Shared kitchens should be cleaned and disinfected at least twice daily, when dirty and after each use. If groups are taking turns using the kitchen on a staggered basis, the kitchen should be cleaned and disinfected after each group. Cleaning and disinfection should include used utensils, countertops and sinks, knobs of small appliances, and handles on appliances like the stove, refrigerator and microwave.
- Commonly used cleaners and disinfectants are effective against COVID-19. Look for disinfectants with a Drug Identification Number (DIN; 8-digit number) and ensure it is safe to use on food surfaces such as in the kitchen. Follow manufacturer's directions on appropriate use. For instance, ensure the product is left on the surface for the right length of time, then rinsed off if the instructions indicate this when used on food surface areas such as kitchen counters.
- Table tops and arms of chairs can be cleaned and disinfected after each meal and when dirty. If groups are taking turns using the dining room on a staggered basis, table tops and the arms of chairs can be cleaned and disinfected after each group.
- Move furniture to support keeping a 2 metre (6 foot) distance apart and use tape on the floor to indicate where furniture should stay. Tables and chairs should be as far apart as possible (at least 2 metres/6 feet apart), and chairs should be set up so that residents are not directly facing each other. Block off or remove every other seat.
- Mark the floors with tape every 2 metres to increase spacing for residents standing in lines for meals.
- Remove shared items like salt and pepper shakers, ketchup, mustard and food containers (e.g., water pitchers, coffee and cream dispensers) and provide single use items.
- Dishes should be washed using normal practices. If a household dishwasher is used, dishes should be washed on the highest possible temperature setting (e.g., avoid using cold water or energy saver cycles). Trays should be washed between use.

Infection Prevention and Control (IPAC) Guidance

This chapter addresses questions related to infection prevention and control practices.

Q1. What are the IPAC best practices for congregate living settings (e.g., hand hygiene, environmental cleaning, washroom supplies, personal hygiene items etc.)?

Written May 24, 2020

Residents should frequently clean their hands.[6] Hands should be cleaned with liquid soap and water or an alcohol based hand rub (ABHR). Hands should be cleaned:

- upon entering the facility
- before and after touching surfaces or using common areas or equipment
- before eating
- before and after preparing food
- before putting on and before and after taking off a mask
- before touching the face (including before smoking)
- after using the bathroom
- when dirty.

Residents should be reminded to avoid sharing food, drinks, smoking/drug supplies and personal hygiene items. Personal hygiene equipment (e.g., toothbrushes, razors, combs) should be labelled with the resident's name. These items and towels should not be left in common areas where they may be accidentally used by others.

See Environmental Cleaning for additional information.

Q2. What items should be considered in an audit of a facility for compliance with IPAC best practices?

Written May 24, 2020

See COVID-19 Preparedness and Prevention in Congregate Living Settings[30] for a checklist to help with reviewing your practices. Section 7 has information on Infection Prevention and Control.

Q3. How can adherence to IPAC best practices be encouraged to be maintained on an ongoing basis?

Written May 24, 2020

Providing regular education and conducting regular checks may be helpful in reminding staff and residents to follow IPAC Best Practices, with appropriate feedback provided to staff when areas for improvement are observed. The use of cleaning schedules and sign-off lists for completed activities such as routine cleaning may also be helpful.

Q4. What are the IPAC best practices for shelters, and other congregate living settings?

Written May 24, 2020

The following resources to help with IPAC in shelters and other congregate living settings:

- Ministry of Health: COVID-19 Guidance: Congregate Living for Vulnerable Populations[2]

- Public Health Ontario: COVID-19 Preparedness and Prevention in Congregate Living Settings[30]
- Public Health Ontario: Managing COVID-19 Outbreaks in Congregate Living Settings[31]
- Public Health Ontario: Resources on Infection Prevention and Control Fundamentals[25]

Q5. How are routine practices and additional precautions applicable in a congregate living setting?

Written May 24, 2020

- Routine practices[22] are measures that are intended to be followed by staff members who are providing care when there may be contact with blood and/or body fluids. Routine practices include cleaning your hands[6] and using appropriate personal protective equipment (PPE) when indicated.
- involve the use of specific PPE and other practices when care is being provided to an individual who is known or suspected to be infected with a particular germ.
- For COVID-19, Droplet and Contact Precautions[19] are recommended. This means that staff members who provide direct care or service (e.g., feeding, bathing, washing, shaving, turning, changing clothing, toileting, wound care) for residents with confirmed or suspected COVID-19 (including all of the residents in an outbreak area) should wear surgical/procedure masks, eye protection, gowns and gloves. Hands should be cleaned[6] after gloves are removed.

Q6. What are the recommended IPAC practices for shared bathrooms?

Written May 24, 2020

See Section 7 and 8.3 of COVID-19 Preparedness and Prevention in Congregate Living Settings[30] and Cleaning and Disinfection for Public Settings.[26]

- Stagger schedules for using common bathrooms for hygiene (such as washing, bathing, showering, teeth brushing and shaving) so that smaller groups of people use the bathrooms at different times.
- Bathrooms should be cleaned and disinfected between each group of residents if possible, and at least twice daily and when dirty.
- Ensure residents have their own towels and personal items (e.g., toothbrushes, razors, combs) that are not shared. Personal items should to be labelled with a resident's name and stored in the resident's room (not in a shared washroom) in order to prevent accidental sharing.
- Encourage hand washing after using the bathroom.

Q7. How can the health and safety of well individuals in community living settings be maintained if space (e.g., bathrooms) is shared with a confirmed case?

Written May 24, 2020

If you have a case of COVID-19 in a resident or staff in your facility or you have a cluster of ill residents, staff and/or visitors, contact your local public health unit[32] for assistance.

See Section 6.3 of Managing COVID-19 Outbreaks in Congregate Living Settings[31] for information on shared bathrooms.

- If possible, provide a separate bathroom for each group of residents in the outbreak area (see Section 2.2 Managing COVID-19 Outbreaks in Congregate Living Settings)[31] and for residents in the non-outbreak area.
- Provide a schedule for use of the bathroom for hygiene activities (e.g., washing, bathing, showering, teeth brushing and shaving) so that residents can remain as far apart as possible while in the bathroom.
- If a COVID-19 positive resident or an ill resident who is not known to have COVID-19 must use a bathroom used by another group, ensure they use it when no one else is there and that they wear a surgical/procedure mask. They should clean their hands[6] before and after using the bathroom.
- Ensure shared bathrooms are cleaned and disinfected between use by each group of residents if possible, particularly after use by COVID-19 positive or ill residents and at least twice daily and when dirty.
- Ensure residents have their own towels and personal items (e.g., toothbrushes, razors, combs) that are not shared. Personal items should to be labelled with a resident's name and stored in the resident's room (not in a shared washroom) in order to prevent accidental sharing.

Q8. Can residents/clients use cloth towels to dry their hands if washroom space is not shared?

Written May 24, 2020

If the towel will only be used by one resident in their own washroom and will not be shared, then a cloth towel can be used. Cloth towels should be laundered regularly (e.g., at least twice a week) and when visibly dirty.

Q9. What are the recommended IPAC practices for shared laundry facilities?

Written May 24, 2020

- Gloves are worn when handling dirty laundry if likely to touch items contaminated with blood or body fluid. Gowns should be worn if it is likely the worker's clothing may be contaminated with blood or body fluid while handling laundry.
- Gloves and gowns should be worn when handling dirty laundry.
- Handle laundry gently without shaking.
- Use regular laundry soap and the hottest setting available and dry thoroughly.

- Residents should have their own clean bedding and towels.
- Bedding and towels should be washed on a regular schedule for residents who stay in the facility.
    - Change bedding every one to two weeks
    - Change bath towels after used about three times
- If laundry is done by the residents, create a schedule to avoid having too many people using the laundry room at one time.
  See Section 7.4 of the COVID-19 Preparedness and Prevention in Congregate Living Settings.[30]

During an outbreak refer to Section 7.4 of the Managing COVID-19 Outbreaks in Congregate Living Settings.[31]

Outbreak Management

This chapter addresses outbreak management.

Q1. What is the definition of an outbreak in a congregate living setting?

Written May 24, 2020

- **An outbreak is defined** as one or more cases of COVID-19 in a resident or staff associated with the facility.
- **A possible outbreak** is a cluster of ill residents, staff and/or visitors.

Q2. What are the recommended steps to managing an outbreak in a congregate living setting?

Written May 24, 2020

Refer to Managing COVID-19 Outbreaks in Congregate Living Settings[31] for the recommended steps in outbreak management.

Q3. How should an outbreak be managed in an apartment-style congregate living setting?

Written May 24, 2020

- Contact the local public health unit[32] if an outbreak is suspected in a congregate living setting. The health unit will help manage outbreaks that involve congregate living settings as well as outbreaks that would not be considered congregate living settings because they have no shared living spaces (i.e., separate apartments with no shared kitchens, dining areas, living rooms or bathrooms).
- Residents should be encouraged to remain in their apartments and avoid the common areas of the building. If meal service is provided, meals should be served in the residents' rooms if at all possible.
- Residents should clean their hands as soon as possible after touching surfaces like elevator buttons, doorknobs and hand rails.
- Clean and disinfect[26] frequently touched surfaces at least twice daily and when dirty using usual cleaning supplies.
- Monitor each resident twice daily to determine who is sick and to determine if sick residents need to seek health care.

Refer to Managing COVID-19 Outbreaks in Congregate Living Settings[31] for the additional information applicable to congregate living settings (i.e., buildings with shared living spaces).

Q4. How should an outbreak that is limited to a single unit/floor be managed compared to a facility-wide outbreak?

Written May 24, 2020

Your local public health unit[32] will work with you to decide if an outbreak area should be limited to one or more units/floor or should be declared in the whole facility. This may depend on: how many cases you have in the facility; how residents and staff mix between the various units/floors of the facility; and the layout of the facility. Even if the outbreak area is only defined in part of the facility, it is very important to watch for more cases on all the floors/units in the facility.

Use of Shared Spaces and Physical Distancing

This chapter addresses use of shared spaces and physical distancing.

Q1. How can physical distancing be maintained for people who smoke?

Written May 24, 2020

- If there is a designated smoking area outside the facility, use tape to mark spots 2 metres (6 feet) apart. Ensure the tape will hold up if it gets wet.
- If the smoking area is small, consider moving to a larger area, while still observing local smoking by-laws. If possible, move smoking areas to a section of the property that cannot be accessed by the public to prevent others from joining the smoking area.
- Post signage encouraging physical distancing and discouraging sharing of cigarettes/vaping equipment.
- Create a schedule for staff and residents regarding use of the smoking area at specific times. Consult with the residents and staff about their needs.
- Offer help to stop smoking if appropriate.

Q2. How can the potential for transmission of infection be minimized in settings where residents cannot comply with physical distancing or self-isolation (e.g., due to physical or cognitive issues, or difficulty with comprehending instructions)?

Written May 24, 2020

- Other residents and staff should be encouraged to remain 2 metres (6 feet) apart from the resident who is unable to comply with physical distancing measures.
- Staff should wear appropriate personal protective equipment[21] (PPE) depending on whether the resident is ill or not and the type of care or service they are providing. For residents ill with symptoms that could be COVID-19,[15] staff should wear a surgical/procedure mask, eye protection and a gown. Gloves should be used when providing direct care or service to the residents. Hands should be cleaned[6] after gloves are removed.
- The resident should be encouraged to wear a mask, if tolerated to lower the chances of spreading infection to others if this can be done safely as follows:
    - Non-medical mask[7] if the resident is not ill;
    - Non-medical mask[7] if the resident is in isolation as a new admission in the previous 14 days (but is not ill);
    - Surgical/medical mask if the resident is ill or in an outbreak area.

See the Public Health Agency of Canada's guidance on Appropriate use of non-medical mask or face covering.[20] It notes that non-medical masks or face coverings should not be worn by children under 2 years, or placed on anyone who cannot take them off without assistance, or anyone who has trouble breathing.

- The resident should be encouraged and assisted (if appropriate) with frequently cleaning their hands[6] using liquid soap and water or an alcohol-based hand rub (ABHR).

- If an ill resident refuses or is unable to self-isolate, places they sit and if possible, objects they touched should be cleaned and disinfected afterwards.

- Ensure frequently touched surfaces and objects are cleaned and disinfected[26] at least twice a day and when they look dirty. Examples of frequently touched objects include: doorknobs, elevator buttons, light switches, counters, hand rails, touch screen surfaces, keypads and table tops.

Q3. How should common areas be managed within a home/facility to minimize the potential for spread of infection?

Written May 24, 2020

- Discontinue activities that require close contact, including group in-person meetings.

- Stagger schedules for using common areas, shared kitchens, shared bathrooms, dining areas for meals and staff break rooms, so that smaller groups of people use these areas at different times.

- Move furniture to encourage keeping a 2 metre (6 foot) distance apart and use tape on the floor to indicate where furniture should stay. Tables and chairs should be as far apart as possible, at least 2 metres apart. Chairs should be set up so that residents are not directly facing each other. Block off or remove every other seat. Mark the floor with the locations where the seats should stay.

- Mark the floors with tape every 2 metres to increase spacing for residents standing in lines for meals or other services.

See Section 8 of COVID-19 Preparedness and Prevention in Congregate Living Settings.[30]

During an outbreak refer to Section 6 of Managing COVID-19 Outbreaks in Congregate Living Settings.[31]

Q4. How can programming be provided while maintaining physical distancing?

Written May 24, 2020

- All group activities that require close contact should be discontinued, including group in-person meetings.

- Consider if the layout of the facility allows for some group activities to continue while maintaining physical distancing (2 metres/6 feet apart) between resident. Consider activities with residents sitting in their doorways or otherwise spaced at least 2 metres apart such as doorway dinners, trivia, music, and Bingo.

- Schedules for using common areas should be developed so use is staggered.

- Outdoor activities where residents can remain physically distant should be encouraged.

- Access to phones, computers, internet, television, video games or other activities, if available, is supported in a way that allows physical distancing.

    - Residents are encouraged to clean their hands before and after activities and using any equipment.

- Shared equipment is cleaned and disinfected after use by each person (using products that are safe for electronic equipment).
- If phones are shared and cannot be appropriately disinfected between use, cover them with a new disposable plastic bag for each use.

- Consider activities that are dedicated to each resident and not shared such art supplies, puzzles, books, games or cards.

Q5. How can the provision of direct care be performed while trying to maintain physical distancing?

Written May 24, 2020

When providing direct care or service (e.g., feeding, bathing, washing, shaving, turning, changing clothing, toileting, wound care) when there is **no COVID-19 in the facility**, staff members should wear the appropriate personal protective equipment[21] (PPE) depending on the type of activities to be provided and the health status of the resident. Residents should wear a non-medical mask,[7] if tolerated.

When providing direct care or service (e.g., feeding, bathing, washing, shaving, turning, changing clothing, toileting, wound care) **for residents with confirmed or suspected COVID-19 (including all residents in an outbreak area**), staff members should wear surgical/procedure masks, eye protection, gowns and gloves. Hands should be cleaned[6] after gloves are removed. Residents should wear a surgical/procedure mask, if tolerated.

To minimize physical contact with the residents, try to provide advice, support, verbal instructions and counselling as needed. If physical contact is needed, try to group the care to avoid multiple visits to the resident. Consider how encounters be can done differently, such as leaving medication 2 metres (6 feet) away from the client and observing them taking the medication.

Q6. Does physical distancing need to be performed if a group of residents normally resides in close proximity to one another and rarely leave the facility?

Written May 24, 2020

Ideally, physical distance[18] is maintained between all residents in a facility. However, physical distancing may be more challenging in small facilities where residents' interactions are more like family members. Staff and essential visitors must wear a mask (non-medical or surgical/procedure mask depending on the activities being undertaken)[2] at all times to help prevent introducing COVID-19 into the facility.

Mask Use

This chapter addresses use of masks.

Q1. Is universal masking recommended for congregate living facilities?

Written June 16, 2020

See COVID-19: Personal Protective Equipment (PPE) and Non-Medical Masks in Congregate Living Settings[33]

When there is not an outbreak in the facility:

- Non-medical masks[7]are recommended to be worn by all staff and visitors for source control (to reduce risk of spread to others).
- Residents who are well should be offered a non-medical mask to wear when they may be within 2 metres of others. Residents who come and go from the facility should be encouraged to wear the non-medical mask when they may be within 2 metres of others, if tolerated.
- Residents with any symptoms that could be COVID-19[15] should be provided with a surgical/procedure (medical mask) and encouraged to wear it if they have to be within 2 metres of others.

In the outbreak area of a facility:

- A surgical/procedure mask, eye protection and gown should be worn by staff and essential visitors at all times when interactions with residents are possible. Gloves should be added when providing direct care. (Direct care may include helping with feeding, bathing, washing, turning, changing clothing, toileting and wound care.)
- A surgical/procedure mask and eye protection (without the gown) should be worn by staff members when interactions with only other staff members are possible (e.g., in staff break areas).
- Residents should be provided with a surgical/procedure mask and encouraged to wear it when they have to be within 2 metres of others, if tolerated.

Masks should not be worn by children under 2 years of age, those who cannot remove the mask themselves, and those with difficulty breathing. The Public Health Agency of Canada has additional recommendations regarding homemade (non-medical) masks.[20]

Q2. Do masks need to be worn if residents/staff remain on site and rarely leave the facility?

Written June 16, 2020

When there is no outbreak in the facility, staff and visitors should wear a non-medical mask for source control for the duration of their shift or visit. Residents should be offered a non-medical mask. The safest approach is for all residents to wear a non-medical mask when physical distancing from others is not possible, recognizing that this may be challenging to maintain on an ongoing basis. Facilities where residents rarely leave are at lower risk for introduction of virus if all staff members consistently wear a non-medical mask, and practice physical distancing inside and outside of the facility as much as possible. The chance of introduction of virus into the facility from visitors is lowered by visitors wearing a mask and maintaining physical distancing.

See Q1 of Mask Use Section for recommendations during the outbreak area of a facility.

Q3. Do masks need to be worn by children (over the age of 2)?

Written June 16, 2020

Masks (regardless of type) should not be worn by children under the age of 2, anyone who cannot remove the mask on their own or anyone who has difficulty breathing. Children over the age of 2 years and/or their parents or guardians should be offered a non-medical mask for source control. Children should be supervised when wearing masks.

The Public Health Agency of Canada has additional recommendations regarding homemade (non-medical) masks.[20]

Q4. Do masks need to be worn if physical distancing is being maintained?

Written June 16, 2020

In a facility that does not have an outbreak, staff and visitors are to wear non-medical masks for the duration of their shift or visit as per the Ministry of Health guidance.[2] In general, residents do not need to wear a non-medical mask if they are able to remain physically distant from others, but may choose to wear one.

See Q1 of Mask Use Section for recommendations during the outbreak area of a facility.

Q5. When are homemade masks versus surgical/procedure (medical) masks indicated to be worn?

Written June 16, 2020

Non-medical masks (including homemade masks):

- It is recommended that when a facility does not have a COVID-19 outbreak, all staff and visitors wear non-medical (e.g. cloth) masks during their shift or visit. Masks can be removed for meals (but the staff member must remain 2 metres from others) or if alone in a private room.
- Residents should also be offered non-medical masks. Residents who come and go from the facility should be encouraged to wear the mask, if tolerated, when they will be near others (within 2 metres).
- When there is no outbreak in the facility, a surgical/procedure mask may also be part of the appropriate personal protective equipment[21] when providing direct care (which may also include eye protection, gloves and a gown). Direct care may include helping with feeding, bathing, washing, turning, changing clothing, toileting and wound care. The PPE to wear will depend on the type of care being provided and the health status of the resident.
- For residents in 14 day isolation upon admission to long stay settings,[2] a surgical/procedure mask, eye protection, gown and gloves should be worn when staff are providing direct care.

Surgical/procedure masks:

- Surgical/procedure masks should be worn by residents who are ill for source control if they have to be near others (within 2 metres).

- During an outbreak in the facility, surgical/procedure masks (along with other personal protective equipment) are worn by staff and essential visitors. Residents are offered and encouraged to wear a surgical/procedure mask if they have to be near others (within 2 metres).

Q6. When do residents need to wear masks?

Written June 16, 2020

- When there is no outbreak in the facility, residents should be offered non-medical masks.[7] In facilities where residents who come and go from the facility, residents should be encouraged to wear the mask if tolerated when they will be near others (within 2 metres). They should also be encouraged to wear the mask when outside of the facility.

- Residents who are ill or in an outbreak area should be offered a surgical/procedure mask and encouraged to wear it when they will be near others (within 2 metres).

Q7. What are best practices related to mask use?

Written June 16, 2020

- Public Health Ontario has a fact sheet on how to wear a mask.[34]
- Hands should be cleaned[6] before putting on and after removing masks.
- Masks should cover the nose and mouth.
- Do not touch the front of the mask. Remove the mask using the straps or ear loops.
- Masks should not be shared with others.
- Non-medical masks should be laundered regularly, preferably after each use or daily and also launder when dirty.
- If possible, use a surgical/procedure mask only once, and throw it in the garbage after it is removed. Information on when to change masks when working in an outbreak can be found in the document entitled How to Cohort During an Outbreak of COVID-19 in a Congregate Living Setting.[35] Surgical/procedure mask should also be changed when they become damp or dirty.

Q8. Can a face shield be worn without a mask if a resident, staff or visitor cannot tolerate a mask?

Written June 28, 2020

- **For source control**, face shields are likely not as effective as a mask because droplets can escape around the sides and bottom of the face shield.

    - For source control for a **resident**, a face shield is a reasonable alternative if a mask cannot be worn (i.e., the mask cannot be tolerated or cannot be worn safely), assuming the face shield can be worn safely and is tolerated.

    - For source control for **staff and visitors**, a mask is preferred, although the face shield would likely be better than no source control at all. If the mask cannot be worn by a staff member or visitor, the management of the facility and local public health unit should discuss whether a face shield is a reasonable alternative. This will depend somewhat on the risk of COVID-19 in the community and within the facility.

- **For personal protective equipment**, face shields alone are not as effective as a surgical/medical mask along with the face shield, as droplets and/or fine particles (aerosols) may enter around the sides and bottom of the face shield.
    - A face shield alone should not be used for personal protective equipment.

Personal Protective Equipment (PPE)

This chapter addresses use of personal protective equipment.

Q1. What is the difference between masking for source control and masking as part of PPE?

Written June 16, 2020

Masks as source control: When someone wears a mask to protect those around them, this is known as source control.[36] Source control works by containing infected droplets from the mouth and nose of the wearer so they cannot easily spread to others. The mask helps to protect others from the wearer's coughs, sneezes, talking and breathing. A non-medical[7] (cloth) or surgical/procedure (medical) mask can be worn for source control.

- **Non-medical masks:** Non-medical masks[7] are not PPE but are used to help protect others from any respiratory infection the wearer may have (source control). It is recommended that when a facility does not have a COVID-19 outbreak, all staff and visitors wear non-medical (e.g. cloth) masks during their shift or visit (except when eating, when staff should stay 2 metres from others, or when alone in a private space). Residents should also be offered non-medical masks.

- **Surgical/procedure masks:** Surgical/procedure masks should be used for source control for anyone who is ill. During an outbreak, surgical/procedure masks should be worn by staff and essential visitors and encouraged for residents. The surgical/procedure mask will offer source control as well as PPE (along with other recommended equipment).

Masks should not be shared. Non-medical masks should be laundered regularly (preferably after each use).

Masks as personal protective equipment (PPE): When someone wears a mask to protect themselves from potential exposure to infection, this is using a mask as part of PPE. Masks for PPE should always be surgical/procedure masks. For example, a staff member should wear a surgical/procedure mask it they provide direct care to a person with COVID-19 or someone with a respiratory illness, or if working in an outbreak-affected area.

Q2. What type(s) of PPE need to be worn when there are no cases in the facility?

Written June 16, 2020

When there are no cases of COVID-19 in the facility, PPE will be selected as per usual practice. Appropriate personal protective equipment[21] (which may include a surgical/procedure mask, eye protection, gown and gloves) are worn when providing direct care to a resident. Direct care may include helping with feeding, bathing, washing, turning, changing clothing, toileting and wound care. The type(s) of PPE to be worn will depend on the type of care being provided and the health status of the resident.

For residents in 14-day isolation following admission to long stay settings,[2] a surgical/procedure mask, eye protection, gown and gloves should be worn when staff are providing direct care.

Q3. Can gloves be disinfected and reused?

Written June 16, 2020

No. Gloves should never be disinfected and re-used. Gloves should only be worn once (i.e., for a single task) and then discarded. Hands should be cleaned before putting on and after removing gloves.

Q4. What type(s) of PPE need to be worn by various staff (e.g., those providing direct care, those not within 2 meters of residents, when residents cannot remain physically distant etc.)

Written June 16, 2020

See Personal Protective Equipment (PPE) and Non-Medical Masks in Congregate Living Settings[33]

If there is no outbreak in the facility, non-medical masks are to be worn for source control. PPE is only required for direct care[21] (depending on what care is being performed and the health status of the resident) or for providing care to residents who are in 14-day isolation following admission (see Q2 in Personal Protective Equipment (PPE) section).

In the outbreak area of a facility, a surgical/procedure mask, eye protection (e.g., face shield, goggles) and a gown are to be worn at all times when there may be an interaction with a resident. Gloves are to be worn when providing direct care to residents. A surgical/procedure mask and eye protection (without a gown) should be worn in staff only areas.

PPE should be properly taken on and off[24] and hands should be cleaned.[6]

Q5. When is the use of an N95 respirator indicated?

Written June 16, 2020

An N95 respirator is a special face covering that protects the wearer against very small airborne particles. It must fit the wearer's face properly which is assessed by a process called fit-testing.

N95 respirators are not required unless an aerosol-generating medical procedure[37] (AGMP) is being performed for a resident who has or may have COVID-19, such as in an outbreak area of the facility. Aerosol-generating procedures include continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP) and deep open suctioning of a resident with a tracheostomy. An N95 respirator is not required if the resident is not known or suspected to have COVID-19 (i.e., the N95 respirator is not required if not in an outbreak area). If an N95 respirator is needed, it should be worn along with other appropriate personal protective equipment.

In general, AGMPs should not be performed in congregate living settings for residents who have or may have COVID-19. The resident's health care provider should be consulted regarding the management of a resident who has or may have COVID-19 and needs an AGMP.

Q6. When do gloves need to be worn? E.g., should these be provided for visitors/staff who may be touching elevator buttons or door handles?

Written June 16, 2020

- Gloves are not needed if touching elevator buttons and door handles. Hand should be cleaned[6] after touching any of these surfaces. Touchless options should be used if available (i.e., automatic door openers,) or using your elbow if possible. Frequently touched surfaces should be cleaned and disinfected[26] at least twice daily and when dirty.

- Gloves, along with a surgical/procedure mask, eye protection and a gown, are required when providing direct care to a resident who has or may have COVID-19, such as in an outbreak area of the facility. Direct care may include helping with feeding, bathing, washing, turning, changing clothing, toileting and wound care.

- If there is no COVID-19 in the facility, appropriate personal protective equipment[21] (which may include gloves, along with a surgical/procedure mask, eye protection and gown) are worn when providing direct care to a resident as per usual practices. The PPE to be worn will depend on the type of care being provided and the health status of the resident.

- For residents in 14-day isolation following admission to long stay settings,[2] gloves, along with a surgical/procedure mask, eye protection and a gown should be worn when staff are providing direct care.

Q7. When surgical/medical masks are indicated, do these need to be a specific level (e.g., do these require fluid resistance)?

Written June 16, 2020

Medical masks (surgical/procedure masks) can be classified according to their fluid resistance[38] (ability to withstand certain pressures of splash or spray). They are rated from Level 1 (lowest) to 3 (highest) in terms of their fluid resistance. For the majority of exposures in the congregate living setting, where it is unlikely that providing direct care will lead to high pressure spray of blood or body fluids, a Level 1 or 2 mask is sufficient.

Q8. How should PPE be put on (donned) and removed (doffed)?

Written June 16, 2020

See here[24] for the recommended steps to putting on (donning) and removing (doffing) PPE.

Q9. Can homemade PPE be used when PPE is in short supply?

Written June 16, 2020

Because PPE must meet certain standards[39] set by Health Canada, homemade PPE (such as gowns) cannot be used.

When a mask is worn for source control and not PPE, a homemade (non-medical, cloth) mask can be used. It should be made of at least two layers of fabric, as per Public Health Agency of Canada recommendations.[20]

See Personal Protective Equipment (PPE) and Non-Medical Masks in Congregate Living Settings[33] for information on when to wear what type of mask and when to wear other PPE.

Q10. Can reusable (launderable) gowns be used when single-use gowns are in short supply?

Written June 16, 2020

Yes, approved reusable gowns can be laundered with regular laundry detergent and washed on the hottest setting available on the machine, then dried well. Wash gowns separately from other laundry. Wear a gown and gloves when laundering gowns.

Disposable gowns should never be reused.

Q11. What types of PPE are required in certain situations, e.g., performing CPR, administration of naloxone?

Written June 25, 2020

Staff will already be wearing some equipment under current COVID-19 Guidance

- In a facility that **is not experiencing an outbreak**, staff will already be wearing a non-medical mask.
- In a facility that **is experiencing an outbreak**, staff will already be wearing a surgical/procedure mask and eye protection, and in some circumstances, a gown; these can be left on when performing CPR or administering naloxone.

Given circulation of COVID-19 and the fact that people can have COVID-19 without any symptoms, it is safest to respond to a resident as if they have COVID-19, regardless of whether there is an outbreak in the facility or not.

Suggestions to prepare for responding to possible overdoses:

Develop and practice an emergency response plan that takes into account personal protective equipment (PPE) required for COVID-19, including:

- Assemble a "response kit" that includes PPE (i.e., surgical/procedure masks, face shields, gowns and gloves) along with overdose response equipment;
- Define a specific location for the response kit;
- Outline a schedule for checking that the response kit has all the required equipment. This should be done on a regular basis;
- Describe and practise a two-responder approach as outlined below; and
- Describe and practise putting on and taking off PPE.[24]

In an emergency:

- **Call 911:** In a medical emergency (e.g., unresponsive person), call 911 without delay.
- **Infection risk:**

- Use PPE as available based on preparation prior to the emergency. Routine PPE includes a surgical/procedure mask, eye protection, gown and gloves.
- Anyone not responding to the emergency should leave the area.

- **Intervention**:
  - Chest compressions, mask and oxygen therapy, or naloxone administration may be performed with routine PPE.
  - Continue to monitor the individual and stay with them until first responders arrive.

- **After**
  - Following the response, take off PPE as recommended[24] and dispose of used items safely. Clean hands[6] as recommended.

Additional information on infection prevention and control and PPE use for emergencies:

- PPE should be put on quickly if it is readily available and should not delay the response. If the responder is wearing a non-medical mask, a face shield (instead of goggles) is preferred if available.
- If PPE is not readily available and obtaining it will delay the response, a two-responder approach can be used if a second responder is available. A second responder could put on all the PPE while the first person is responding. The PPE for the second responder is as follows:
  - **Surgical/procedure mask:** If the second responder is wearing a non-medical mask, they should clean their hands[6] and change to a surgical/procedure mask.
  - **Eye protection**
  - **Gloves:** Gloves will be available in the naloxone kit.
  - **Gown:** Consider a gown if you prefer and it is readily available.
  - Cleaning hands[6] plays an important role in preventing the spread of infection; it is most important and is required after the response is completed. Responders should avoid touching their face during the response.

Prevention and Preparedness

This chapter addresses prevention and preparedness for outbreaks.

Q1. How can congregate living settings prepare for and prevent future outbreaks?

Written June 16, 2020

Congregate living settings can refer to Public Health Ontario's COVID-19 Preparedness and Prevention in Congregate Living Settings[30] document for a checklist of items that can be used to help plan for, prevent and detect COVID-19, including specific guidance on:

- Getting prepared
- Staff and essential visitors
- Screening and monitoring
- Resident spaces
- Testing
- Personal protective equipment (PPE) and source control
- Infection prevention and control (IPAC)
- Activities and meals
- Communications

Q2. What is sentinel surveillance and how can this be conducted in congregate living settings?

Written June 16, 2020

Sentinel surveillance is a method used by public health to monitor a subset of the population for specific symptoms of a disease. It serves as an early warning system (i.e., similar to the function of a 'canary in a coal mine') to quickly detect potential cases and/or clusters of a disease so that measures can be taken to prevent further spread. In the COVID-19 response, testing is being offered broadly to anyone who would like to be tested as well as specific groups at higher risk of infection across the province, so a sentinel surveillance approach is not being used.

Monitoring for COVID-19 in congregate living settings is conducted by screening residents and staff for symptoms of COVID-19[15] prior to and on entry into the facility and twice daily thereafter. Facilities should maintain a daily log to track any illness in staff or residents and any testing that has been done, along with the results.

Resident Placement/Isolation

This chapter addresses resident placement and isolation.

Q1. In what circumstances do residents/clients require private bedrooms and washrooms?

Written June 16, 2020

- Communicable diseases, like COVID-19, are less likely to spread in facilities where each resident has their own private bedroom, and more likely to spread in shared bedrooms.
- If there are limited private bedrooms and washrooms and is occurring in the facility, private rooms can be given to those who are most at risk of developing severe COVID-19 infection (older adults and those with underlying medical conditions).
- If there are limited private rooms and washrooms, prioritize these accommodations (from highest to lowest priority) as follows:

    1. COVID-19 positive resident, if there is only one positive resident in the facility;

    2. Ill but not known to have COVID-19, particularly if older or have underlying medical conditions;

    3. Exposed and well (if tested, COVID-19 negative) who HAD close contact with a known COVID-19 case, particularly if older or have underlying medical conditions;

    4. Exposed and well (if tested, COVID-19 negative) with NO close contact of a known COVID-19 case, particularly if older or have underlying medical conditions.

If there is more than one resident with COVID-19, they can be grouped (cohorted) together in the same room. Other residents with similar illness or exposures may also be able to be grouped (cohorted) together. See How to Cohort During an Outbreak of COVID-19 in a Congregate Living Setting[35] (quick reference fact sheet) and Cohorting in Outbreaks in Congregate Living Settings[40] (more detailed document).

Q2. How should shared accommodations/washrooms be managed if facilities don't have the ability to provide private accommodations for a positive case?

Written June 16, 2020

- If there is only one COVID-19 positive resident in your facility, they should be placed in a single room with a door that closes and have a private bathroom if possible. They should remain in their room and have their meals served in their room and not use the shared dining room. If they must use a shared bathroom, they should try to use it when no one else is there or stay as far away from others as possible (at least 2 metres apart), and wear a surgical/procedure mask for the entire time they are outside of their room (if at all possible, assuming that this is safe and tolerated). They should clean their hands[6] before leaving their room and after using the washroom. Surfaces they touched in the bathroom should be cleaned and disinfected afterwards if possible.
- If there are multiple COVID-19 positive residents in a facility, they can share a room and bathroom (cohorting). See How to Cohort During an Outbreak of COVID-19 in a Congregate Living Setting[35] (quick reference fact sheet) and Cohorting in Outbreaks in Congregate Living Settings[40] (more detailed document).

- If a facility determines that they cannot safely isolate someone who has COVID-19, they may need to move the resident to an offsite location where isolation is possible. Appropriate supports should be available in the offsite location.

Q3. Can a positive resident case of COVID-19 be managed in the facility or does the individual need to be transferred to another location?

Written June 16, 2020

- A resident with COVID-19 can be managed in the facility if:
    - The facility can provide proper isolation (see Q2 in Resident Placement/Isolation section), and
    - The facility can provide the appropriate health care needed by the resident. Sicker residents may need to be cared for in the hospital.
- If a facility determines that they cannot safely isolate someone who has COVID-19, they may need to move the resident to an offsite location where isolation is possible. Appropriate supports should be available in the offsite location.

Q4. How can smoking be facilitated/managed if a resident is in isolation?

Written June 16, 2020

- When possible, support the resident to quit or cut back on smoking by helping them to access nicotine replacement therapy (NRT) or other smoking cessation aids.
- Individuals with COVID-19 or others in isolation who continue to smoke should do so alone outside and should not share tobacco products, lighters or other equipment.
- When going to and from the outdoor smoking location, individuals with COVID-19 and others in isolation should avoid contact with other people. Preferably they should take designated routes that minimize travel through the facility, or travel at times where there are no other people. They should always remain at least 2 metres apart from others and should wear a surgical/procedure mask when traveling to and from the smoking area.
- They should clean their hands[6] before leaving their room and after smoking, and should use hands-free door openers if available. Surfaces they touch should be cleaned and disinfected afterwards if possible.[26]
- Ensure the designated smoking area has an appropriate place to put cigarette butts and other garbage, and that this is emptied frequently.

Return to Work and Screening

This chapter addresses return to work and screening.

Q1. When can a staff member who has been diagnosed with COVID-19 return to work?

Written June 16, 2020

The Ministry of Health provides criteria[12] for when people with COVID-19 are no longer considered infectious. This is when it would be safe for a person with COVID-19 to return to work. As per the criteria:

- A staff member who has COVID-19 can return to work 14 days after symptoms of illness first started, provided that they have no fever and their symptoms have been improving for at least 72 hours.

- If the staff member with COVID-19 had no symptoms (asymptomatic), in general they can return to work 14 days after the positive swab was taken. However, sometimes repeat testing will be recommended and return to work based on these results. Return to work for asymptomatic staff members should be discussed with local public health unit.

Q2. When can staff members who are ill return to work and are they required to wear specific PPE?

Written June 16, 2020

See COVID-19 Quick Reference Public Health Guidance on Testing and Clearance[12] on criteria to return to work.

Staff members who become ill should notify their manager of their illness, and should be tested for COVID-19.

- If they are negative and have had no exposure to COVID-19, they can return to work after symptoms have resolved.

- If they are isolating because of exposure to COVID-19 and have a negative test, they should continue to self-isolate for 14 days and should discuss return to work based on the advice of their manager or occupational health provider, and local public health unit.

- If they test positive for COVID-19, staff members can return to work based on the criteria in Q1 of Return to Work section.

Once a staff member is cleared to return to work, they should wear the same equipment as other staff members in the facility (i.e., mask for source control or personal protective equipment). See Personal Protective Equipment (PPE) and Non-Medical Masks in Congregate Living Settings.[33]

Q3. What symptoms should trigger a staff member not coming to work, or a medical assessment for a resident?

Written June 16, 2020

- Symptoms of COVID-19 are provided in the Ministry of Health's COVID-19 Reference Document for Symptoms.[15]

- If a resident develops symptoms of COVID-19,[15] they should be placed in a private room with a door where they can self-isolate and wait for arrangements to be made for testing and/or health care as needed. If a private room is not available, place the resident in an area away from other

people (at least 2 metres apart). Provide the resident with a surgical/procedure mask and advise them to clean their hands.[6]

- If a staff member develops symptoms of COVID-19[15] while at home, they should not come to work, should notify their manager, and seek testing and/or health care. If a visitor develops symptoms of COVID-19, they should not visit the facility. If they have been at the facility in the preceding 14-days they should notify the facility.

- If a staff member or visitor develops symptoms of COVID-19 while they are at the facility they should tell their supervisor and go to a private room with a door where they can self-isolate and wait for arrangements to be made for testing, health care or transportation home as appropriate. If a private room is not available, place the staff member in an area away from other people (at least 2 metres apart). Provide the staff member or visitor with a surgical/procedure mask and advise them to clean their hands.[6]

Q4. How should screening be done?

Written June 16, 2020

There are two types of screening: passive screening and active screening.

- **Passive screening** means staff and residents monitor and report symptoms of COVID-19.[15] Facilities should post signage listing the symptoms of COVID-19[15] and who to notify if a resident, staff member or visitor becomes ill. Signage should be posted in areas that will be easily visible, including at the entrance, and should be in appropriate languages.

- **Active screening** means regularly asking staff, residents and visitors if they have any symptoms of COVID-19.[15] Screening should be conducted for everyone before entering the facility, including by phone before arrival if possible.

  Residents, staff and essential visitors should be screened twice daily. For staff, volunteers and essential visitors, this can be at the start and end of each shift or visit. For residents, this can be done by walking through the facility and talking with residents twice a day.

For additional information on screening/monitoring, see Section 3 of COVID-19 Preparedness and Prevention in Congregate Living Settings.[30]

Q5. How can screening be facilitated when active screening is not possible (e.g., in a multi-unit residential facility)?

Written June 16, 2020

If active screening of residents and/or staff and essential visitors is not possible (see Q4 of Returning to Work and Screening section for definition of active screening):

- Ensure signs are posted throughout the facility and translated into appropriate languages advising of the symptoms of COVID-19[15] and who to contact if residents, staff or visitors become ill.

- Advise residents who become ill to notify staff members.

- Observe residents for signs of illness and ask them how they feel during routine interactions. Ensure staff know to notify management if they are informed of or notice a resident who appears ill.

- Ensure staff and essential visitors know to notify their manager/supervisor if they feel ill.

Q6. Should temperatures of residents/clients/staff etc. be taken as part of screening?

Written June 16, 2020

- Residents should be monitored for symptoms of COVID-19[15] when entering the building and twice a day when staying in the building. Staff should be monitored for symptoms of COVID-19[15] on entering the building and at the end of their shift. (see Q4 in Return to Work and Screening section).

- The added value of temperature checks as part of routine monitoring is unclear, and they could increase close contact when performed. Check if there are operational requirements for your sector. If performed, temperature checks must be done safely with no-touch thermometers by a person using a surgical/procedure mask and eye protection. No-touch thermometers are preferred; thermometers placed in the mouth should not be used. If ear thermometers are used, they should have disposable covers that are thrown out after each use. Hands should be cleaned[6] if any direct contact with the resident occurs.

Q7. Can non-medical staff conduct screening?

Written June 16, 2020

An appropriately trained person can conduct screening. Individuals conducting screening should be aware of the appropriate precautions to take while screening, what to ask, and how to respond, including who to notify, if any individual has possible symptoms of COVID-19.[15]

For additional information on screening/monitoring, see Section 3 of COVID-19 Preparedness and Prevention in Congregate Living Settings. [30]

Q8. Are screening practices the same for all individuals, or should screening criteria differ for children, the elderly, etc.?

Written June 16, 2020

The COVID-19 Reference Document for Symptoms[15] indicates that atypical (unusual) signs and symptoms should be considered in some populations, such as children, older persons and people living with a developmental disability. In addition, some individuals such as young children and some people with developmental disabilities or cognitive impairments may not be able to express that they are feeling unwell. These individuals should be monitored frequently for changes in how they look and in their behaviour.

Q9. How can the symptoms of COVID-19 be differentiated from other conditions (e.g., substance withdrawal, those that are 'typical' for a client).

Written June 16, 2020

For details on symptoms, including atypical (unusual) symptoms, please refer to the COVID-19 Reference Document for Symptoms.[15]

- For people who use substances or who have chronic symptoms, it may be difficult to tell the difference between symptoms of withdrawal or pre-existing illness and symptoms that could be COVID-19. Knowing the resident and their usual responses and behaviours may help. A known exposure to COVID-19 in the facility or community may also help in determining if symptoms are more likely to be due to COVID-19.
- If a person has symptoms that could be due to COVID-19, they should be isolated and further assessment and testing should be completed. Consult with the individual's healthcare provider or Telehealth (1-866-797-0000) for advice.

Staffing

This chapter addresses staffing related questions.

Q1. What information can be given to staff who are entering various homes/facilities in the community?

Written June 16, 2020

Staff should follow guidance from their relevant Ministry, local public health unit, and regulatory college (if applicable). Wherever possible, staff should work at a single facility. If staff travel from one facility to another, they should ensure that they use appropriate personal protective equipment (PPE) in every home and never carry used PPE from one facility to another.

If staff work in more than one facility and there is an outbreak in one of these facilities, this should be discussed with their local public health unit, as traveling between facilities is not advisable.

Q2. Do staff need to change uniforms and/or footwear when entering or leaving a facility?

Written June 16, 2020

- Footwear does not need to be changed when entering or leaving a facility.
- **If there is no outbreak in the facility**, staff may travel to and from work in their uniforms but may choose to change on site, based on personal preference and availability of changing areas.
- **If the facility has an outbreak**, gowns will be worn to protect uniforms in the outbreak area. If possible, it is best for staff to change their uniform before traveling home at the end of a shift.

The facility may have specific requirements regarding wearing uniforms outside of the facility.

Support

This chapter addresses providing support to residents.

Q1. How can facilities support residents with addictions during physical distancing and isolation?

Written June 16, 2020

Supports:

- Provide access to support services that may include addiction and physical and mental health services. Further information is available from the Ministry of Health's COVID-19 Fact Sheet: Resources for Ontarians Experiencing Mental Health and Addictions Issues During the Pandemic.[41]
- Ensure residents have access to opioid agonist treatment (e.g., methadone, suboxone) and nicotine replacement therapy as appropriate.
- Contact the local needle and syringe program to access safer drug use supplies.
- Consider overdose prevention planning, including access to naloxone.
- Monitor for alcohol withdrawal and ensure access to appropriate care.
- Encourage residents not to share drugs or equipment, including anything that is put into the mouth (e.g., cigarettes, pipes, vapes).
- Encourage residents to clean their hands[6] before using drugs, including before any activities that require touching their mouth or nose.
- Support residents to keep a 2 metre distance from others.
- Encourage residents to use a non-medical mask if they may be near other residents (within 2 metres).
- Provide appropriate biohazard containers for safe disposal of used needles and syringes.

Q2. How can client/resident mental well-being be supported during physical distancing and isolation?

Written June 16, 2020

Support residents to keep in touch with their friends and family by phone, text, or computer. For those currently receiving or needing mental health and addictions services, supports or information, many providers are offering virtual care options, including meeting clients by phone or secure video-conferencing, and offering supports or information on-line or by phone. Use a trauma informed approach to providing care which is an approach to increase a sense of safety and control among those seeking services.

For more information, refer to Public Health Ontario's Take Care of Yourself and Each Other[42]and the Ministry of Health's Mental health, wellness, and addictions support page[43] and COVID-19 Fact Sheet: Resources for Ontarians Experiencing Mental Health and Addictions Issues During the Pandemic.[41]

For more information on trauma informed care, see:

- Public Health Agency of Canada, Trauma and violence-informed approaches to policy and practice[44]

- Canadian Public Health Agency, Trauma- and violence- informed care toolkit for reducing stigma related to sexually transmitted and blood-borne infections (STBBIs)[45]

- Centre of Excellence for Women's Health, Trauma, Violence & Mental Health[46]

Q3. How can individuals with behavioural/emotional/mental health issues be supported while following public health recommendations?

Written June 16, 2020

- Uncertainty related to COVID-19 may worsen symptoms of pre-existing behavioural, emotional, or mental health issues. Reassure residents that some fear and anxiety is a normal response to COVID-19.

- Offer as much accurate, developmentally-appropriate information as possible about COVID-19, and the COVID-19 planning and preparation being done by the facility.

- Involve residents in the planning if possible and encourage them to ask questions and provide suggestions.

- Provide residents access to credible information sources about COVID-19, like the Ministry of Health's COVID-19 page[47] and Public Health Ontario's COVID-19 resources for the public.[48]

Refer to the Ministry of Health's COVID-19 Fact Sheet: Resources for Ontarians Experiencing Mental Health and Addictions Issues During the Pandemic[41] for more information and resources.

Q4. How can individuals who have resided together for years be supported when one of them needs to be isolated?

Written June 16, 2020

- With the consent of the resident in self-isolation, explain why this is needed to the other residents.

- With the consent of the resident in self-isolation, provide updates on their health status to other residents.

- Support residents to keep in touch with each other by phone, text, or computer while remaining physically separated.

For more information, refer to Public Health Ontario's Take Care of Yourself and Each Other[42]

Q5. How can barriers to testing and self-isolation be identified and addressed?

Written June 16, 2020

Testing

- Explore options for on-site testing which may include: local assessment centres coming onsite, health care providers associated with the facility or who have offered to provide onsite testing services in your community, or emergency medical services. If you have difficulties organizing testing, contact your local public health unit for information.

- Explore options for off-site testing which may include: local assessment centres, health care providers or clinics.
- Ensure the organization doing the testing is aware of the needs of your residents.
- Ensure residents are well prepared for the testing, including why it is being done and what to expect (i.e., swab in the nose, not generally painful but feels strange, done very quickly).
- Ensure results are clearly communicated to residents along with what they mean with regard to next steps. See You Were Tested for COVID-19: What You Should Know.[49]

Self isolation

- Identify off-site locations for self-isolation or areas of the facility that can be safely used for self-isolation. If possible, residents in self-isolation should be provided with their own bathroom and meals in their room.
- Ensure residents in self-isolation have appropriate physical and mental health and social supports, including if the residents are placed off site.
- Ensure residents understand the reason for self-isolation, how long it will last and the supports that will be provided to them while in self-isolation (e.g., activities to keep them busy, counselling).
- Ensure social connections between the resident and other residents and friends and family are maintained via computer or telephone and that there are frequent staff interactions (using appropriate personal protective equipment and physical distancing).

Q6. How can residents be provided with autonomy while still limiting the risk of exposure to COVID-19?

Written June 16, 2020

- Offer as much information as possible about COVID-19. Discuss the reason there is concern about the virus and the risk of it entering and spreading in the facility.
- Involve residents in the planning if possible and encourage them to ask questions and provide suggestions.
- Discuss mechanisms that residents can prevent getting and spreading infection, both while in the facility and if they go into the community and come back into the facility. These include:
    - limiting interactions with others outside the facility if possible;
    - staying 2 metres apart[18] from others as much as possible;
    - wearing a non-medical mask[7] when they may be near others;
    - cleaning hands frequently;[6]
    - coughing and sneezing into a tissue or elbow[5] followed by cleaning hands; and
    - watching for and reporting symptoms that could be COVID-19.[15]

Q7. How can adults and children be supported in going outdoors and for walks?

Written June 16, 2020

When there is no outbreak in the facility:

- Going outside and walking and other exercise is very important for physical and mental health.
- The same physical distancing[18] measures should be followed outside as inside, including staying 2 metres (6 feet) apart from other residents and staff as much as possible, while ensuring safety of the residents when outside.
- Avoid contact with others outside the home. Consider the following if necessary:
    - Choosing less busy times to go outdoors (e.g., early morning)
    - Avoid crowded areas (e.g., popular trails, main streets)
- If there is concern that physical distancing may be hard to maintain, wear or carry non-medical masks[7] that can be put on if needed.
    - Non-medical masks should not be used by children younger than 2 years of age, those who cannot tolerate them or have breathing problems, or those who cannot remove them themselves.
- Avoid touching surfaces touched by others (e.g., buttons, hand rails, park equipment, benches).
- Staff and/or residents (if safe and appropriate) should carry alcohol-based hand rub[6] to be used on hands if surfaces outside are touched.

Assuming there is no outbreak and the resident is well, residents in isolation upon admission (for a stay that is expected to be longer than 14 days) can go for walks if they can remain apart from others (more than 2 metres apart). If a staff member must accompany the resident, they should wear a surgical/procedure mask and eye protection and bring along alcohol-based hand rub to use after they touch the resident. In most circumstances, the staff member would not need a gown or gloves. If tolerated, the resident could wear a non-medical mask.

- Residents in the non-outbreak area can go outside following the precautions outlined above for when there is no outbreak in the facility.
- Residents in the outbreak areas should generally remain in their room. However, they can go outside on an individual basis (not as a group) as long as they can be sure to remain apart from others at all times. The following is recommended:
    - The resident should remain on the grounds of the facility.
    - They should wear a medical mask if they can tolerate it.
    - Any staff member accompanying them should use the appropriate personal protective equipment which consists of a surgical/medical mask, eye protection and gown. Gloves should be worn if contact with the resident is likely.

- Staff should carry alcohol-based hand rub[6] to be used on their hands if surfaces outside are touched.

Q8. What resources are available to support the mental health and stress levels of staff?

Written June 16, 2020

- Reassure staff that some fear and anxiety is a normal response to COVID-19.
- Empower staff to take proactive steps to protect themselves and residents, which may include offering education to staff about COVID-19 or engaging staff in facility COVID-19 planning.
- Check in with staff frequently to see how they are doing and feeling and ensure they have the supports they need.
- Listen closely to staff concerns, offer support and resources, encourage questions and suggestions and be responsive to their needs.
- Ensure staff have personal protective equipment (PPE) appropriate to the work they perform and the training needed to use the PPE properly.
- Provide staff access to credible information sources about COVID-19:
  - Ministry of Health's COVID-19 web page[47]
  - Public Health Ontario's COVID-19 resources for the public.[48]
- Refer staff to available resources and supports for managing mental health issues and stress:
  - Public Health Ontario's Take Care of Yourself and Each Other[42]
  - Ministry of Health's Mental health, wellness, and addictions support page[43]
  - Ministry of Health's COVID-19 Fact Sheet: Resources for Ontarians Experiencing Mental Health and Addictions Issues During the Pandemic [41]
- Be aware of what supports are available through your organization or staff's professional or labour organization as appropriate, and consider referral to these resources.

Testing

This chapter addresses testing related questions.

Q1. Do all individuals in the facility need to be tested if there is a single positive case?

Written June 16, 2020

If a case of COVID-19 is identified in the facility, the decision of who else may need to be tested should be made in consultation with your local public health unit. They may recommend that all residents and staff be tested.

Q2. Do residents need to remain in isolation until the results of testing are available?

Written June 27, 2020

The local public health unit can assist with determining when isolation is no longer needed for a resident. The following provides some general information.

For residents who are tested on or prior to admission to the facility because they are expected to stay longer than 14 days:

- They should self-isolate regardless of the test results.

For other residents who are not self-isolating upon admission:

If a resident has never had symptoms and has never been in contact with someone who has COVID-19 and there is no outbreak in the facility:

- They should continue to self-monitor[50] for symptoms and follow usual practices (e.g., staying 2 metres apart[18] from others, monitoring for symptoms,[15] use of a non-medical mask[7] for source control if tolerated, frequently cleaning their hands)[6] while waiting for their test results.
    - **If the test is positive**, they should self-isolate.[51] The local public health unit should be contacted for further advice.
    - **If the test is negative**, they should continue with usual practices as outlined above.

If a resident has symptoms but has never been in contact with someone who has COVID-19 and is not in a facility with a known outbreak:

- They should self-isolate[51] until their test result is available.
    - **If the test is positive**, they should continue self-isolating for 14 days from the day their symptoms started. The local public health unit should be contacted.
    - **If the test is negative**, they should self-isolate until approximately 24 hours after they feel well.

If a person has been in contact with someone who has COVID-19 or is in an outbreak area of a facility:

- **If the test is positive**, they should continue self-isolating for 14 days from the day their symptoms started or the day of their test if they have no symptoms. The local public health unit should be contacted if they are not already involved.

- **If the test is negative**, they should self-isolate until 14 days after their last exposure to the person with COVID-19 or until self-isolation is no longer required by public health as part of outbreak management.

See You Were Tested for COVID-19: What You Should Know [49] for additional information.

Q3. Can residents be tested prior to admission (in conjunction with 14 day isolation following admission)?

Written June 16, 2020

New admissions and transfers to congregate living settings should be screened for symptoms of COVID-19,[15] ideally by telephone before arrival at the facility. In addition, if it is anticipated that the individual will be staying at the facility for more than 14 days, testing for COVID-19 is recommended and this is optimally done prior to admission. Even if testing is done, residents who are likely to stay in the facility for more than 14 days should still self-isolate[51] for 14 days following arrival at the facility.

Q4. When is testing of staff for COVID-19 indicated?

Written June 16, 2020

Testing may be recommended if staff have symptoms that could be COVID-19,[15] if they are a contact of someone with COVID-19, if there is an outbreak in the facility, and possibly for routine monitoring. Your local public health unit can assist with testing advice.

Refer to the current provincial testing guidance for COVID-19 for indications for testing.[52]

Q5. Is there a rapid test for COVID-19 (e.g., for on the spot testing of those who have left the facility for a medical or other appointment)?

Written June 16, 2020

No, at this point in time, a rapid test for COVID-19 has not yet been approved for use in Canada. Health Canada had previously approved a rapid test for COVID-19 in early April, however, after further investigation these test kits were recalled due to concerns about their effectiveness.

Q6. How can on-site testing be facilitated for those that are home-bound, unable to leave the facility or unable to get to a testing centre, etc.?

Written June 16, 2020

As part of the COVID-19 planning process, facilities can work to identify local community health agencies (e.g., local COVID-19 assessment centre, family health teams, primary care physicians, hospitals, emergency medical services) that may be able to do testing at the facility. Facilities can also consult with their local public health unit for assistance in exploring options for on-site testing.

Q7. Are facilities recommended to obtain and have testing kits on-site?

Written June 16, 2020

No, it is not generally recommended that facilities have test kits on-site. For facilities that have an on-site health care centre or health care provider who regularly visits the facility, they may request a supply of test kits for use in congregate living settings.

Q8. Will the turnaround time for test results be prioritized for staff and residents in congregate living settings?

Written June 16, 2020

It is generally difficult to prioritize test results although staff and residents should indicate that they work/live in a congregate living setting when being tested. When testing as part of an outbreak or possible outbreak, expected timing of test results can be discussed with your local public health unit.

Q9. How can access to test results for residents in congregate living settings be facilitated (e.g., will staff be advised of results or do they need to rely on a client to disclose test results)?

Written June 16, 2020

Individuals who have been tested for COVID-19 in Ontario and have a valid Ontario photo health card, can access their test results online at: https://covid19results.ehealthontario.ca:4443/agree.[53] In the event the resident tests positive for COVID-19, the resident or their substitute decision maker will be notified of their positive result by the ordering health care provider or the local public health unit. If a resident tests positive for COVID-19, local public health units will work with facilities to identify and notify the resident's contacts.

Q10. Do residents need to have a negative test prior to admission?

Written June 16, 2020

Check operational guidance for your sector about requirements for test results prior to admission. New admissions or transfers to your facility should be screened for symptoms of COVID-19,[15] ideally by telephone before admission. In addition, if it is anticipated that the individual will be staying at the facility for more than 14 days, testing for COVID-19 is recommended, optimally prior to arrival. Regardless of the test results, residents should still self-isolate for 14 days following arrival at the facility.

Q11. What if a resident declines to be tested?

Written June 27, 2020

If a resident declines to be tested and:

- **The facility has an outbreak,** the resident should self-isolate and be managed as if they are infected (whether they have symptoms or not).
- **The resident has** symptoms of COVID-19[15] **and there is no known outbreak in the facility**, the resident should self-isolate[51] and the local public health unit should be contacted for advice.
- The resident has no symptoms of COVID-19, there is no outbreak in the facility but the **resident has had close contact with someone outside of the facility with COVID-19,** the resident should self-isolate[51] and the local public health unit should be contacted for advice.
- The residents is **being admitted to the facility** and testing is recommended because the stay is expected to be longer than 14 days, the resident should remain in self-isolation for 14 days as recommended for new admissions when the stay is expected to be longer than 14 days.
- If the resident has no symptoms, there is no outbreak in the facility, the resident has no contact with anyone with COVID-19, and the resident is not being newly admitted to the facility (such as when the testing is being done for surveillance (monitoring) purposes), the resident does not require self-isolation and should be cared for as per usual practice.

Worker Isolation/Placement

This chapter addresses worker isolation and placement.

Q1. How should staff who work at multiple facilities/locations be managed?

Written June 16, 2020

- The Ministry of Health's COVID-19 Guidance: Congregate Living for Vulnerable Populations[2] indicates that "employers should work with staff and unions (if applicable) to limit the number of work locations where staff work in order to minimize risk".

- Staff who work at more than one facility or location should discuss options with their employer. They should ensure they follow all recommendations for personal protective equipment and masking for source control at all facilities where they work. See Personal Protective Equipment (PPE) and Non-Medical Masks in Congregate Living Settings.[33]

- In an outbreak, staff should not work at other facilities.

Q2. What are the recommended practices for staffing in order to minimize COVID-19 related risks?

Written June 16, 2020

- Staff are recommended to limit their number of work locations, in consultation with their employer and union (as applicable). If a facility has a COVID-19 outbreak, staff who have worked at that facility should not work elsewhere. (see Q1 in Worker Isolation/Placement section)

- Staff should wear a non-medical mask[7] for source control at all times when in a facility that does not have an outbreak, as well as follow additional recommendations for personal protective equipment (PPE) for direct care and when in an outbreak area. They should put on and take off their PPE appropriately.[24]

- Staff should frequently clean their hands[6] and cough and sneeze[5] into a tissue or their sleeve and then clean their hands.

- They should ensure that they follow the recommendations for masking for source control and physical distancing even when interacting with other staff members (e.g., when on breaks, if travelling to and from work with other staff members).

- Staff members should follow provincial recommendations[47] about physical distancing and interactions with others when not working.

- When there is an outbreak of COVID-19 in a facility, staff should ideally be assigned (cohorted) to work with specific groups of resident during their shift. If possible they should not move from one group to another during their shift. See How to Cohort During and Outbreak of COVID-19 in a Congregate Living Setting.[35]

- Staff should self-assess for symptoms of COVID-19 daily before coming to work, conduct twice-daily screening for symptoms of COVID-19 while at work, and report any symptoms to their manager. Staff with symptoms of COVID-19 should seek testing for COVID-19 and self-isolate[51] while waiting for their test results. They should not come to work when ill.

Q3. If staff work with COVID-positive residents, do they need to self-isolate for 14 days before working elsewhere?

Written June 16, 2020

The local public health unit will provide advice around exposures to COVID-19. In general, staff who have worked with COVID-19 positive residents or in a COVID-19 affected area are required to self-isolate,[51] unless they have used appropriate personal protective equipment at all times, in which case they will be asked to self-monitor.[50] In either case, they should not work at any other facility until the outbreak is declared over or at least 14 days have passed from their last contact with the outbreak facility (assuming they remain well). The local public health unit and employer will decide when, and under what conditions, the staff member can return to work in the outbreak facility.

Q4. What are the best practices for staff within a facility to prevent staff-to-staff transmission of illness?

Written June 16, 2020

It is very important for staff members to continue to take precautions when with each other as well as when with residents. This includes when they are at work, if they carpool or travel on public transit together or if they meet socially. They should maintain physical distancing from each other at all times and wear a mask for source control.

See Q2 in Worker Isolation/Placement section. In addition, some specific suggestions include:

- Move furniture and use tape on the floor to help maintain 2 metre distances to promote physical distancing in staff-only spaces like lunchrooms and offices.
- When possible, use private transportation to and from work.
- Staff should not share equipment if possible (e.g., pens, keyboards, phones). Anything that must be shared should be cleaned and disinfected[26] between uses and hands cleaned[6] before and after use.
- Masks should not be removed in staff-only areas, except to eat (when staff should remain at least 2 metres from others) and if alone in a private room.

Q5. For staff who typically reside on-site, where should the staff member self-isolate when ill (their own accommodation, hotel, alternate location etc.)?

Written June 16, 2020

This answer will depend on whether the staff members is isolating because of exposure/illness at the facility (such as when the facility is in an outbreak), or if the staff member has been exposed outside the facility and is the only one who is in self-isolation. It will also depend on whether the staff member has their own private room and bathroom.

If there is an outbreak in the facility, an exposed or ill staff member may be more likely to be able to stay at the facility. As well, they may be more likely to be able to stay at the facility, if the staff member has a private room and bathroom. However every facility and situation is different, so decisions will need to be made with your local public health unit, depending on the particular circumstances.

Q6. Are staff permitted to come to work if they have an ill household member?

Written June 16, 2020

A staff member who **lives with someone who has COVID-19** is considered to be a close contact with a high risk exposure, unless the staff member had no contact with their sick household member when the household member was infectious. Close contacts with high risk exposures to COVID-19 must self-isolate and monitor for signs and symptoms for 14 days following their exposure. In general, self-isolation[51] means staying at home without any visitors, so a staff member who lives with someone who has COVID-19 should not come to work. Even if the staff member tested negative for COVID-19, they need to continue to self-isolate for 14 days following their exposure.

If the household member is **ill with** possible symptoms of COVID-19[15] **but the cause is not certain**, the ill household member should be tested for COVID-19.

- If the ill household member is not known to have contact with anyone with COVID-19 and tests negative, the staff member can return to work as long as they feel well.
- If the ill household member tests negative but has known contact with someone with COVID-19, the local public health unit can provide advice to the staff members about returning to work.

References

1. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Foundations of COVID-19 prevention and control for congregate living settings [Webinar]. Toronto, ON: Queen's Printer for Ontario; 2020 [presented 2020 May 07; cited 2020 Jun 04]. Available from: https://www.publichealthontario.ca/-/media/event-presentations/pho-webinar-covid-19-congregate-settings-may-5-2020.pdf?la=en

2. Ontario. Ministry of Health. COVID-19 guidance: congregate living for vulnerable populations [Internet]. Version 1 – May 28, 2020. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_congregate_living_guidance.pdf

3. Ontario Agency for Health Protection and Promotion (Public Health Ontario). COVID-19 resources for congregate living settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/congregate-living-settings-resources

4. Ontario Agency for Health Protection and Promotion (Public Health Ontario). COVID-19 routes of transmission – what we know so far [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/wwksf-routes-transmission-mar-06-2020.pdf?la=en

5. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Cover your cough [Internet]. Toronto, ON: Queen's Printer for Ontario; 2015 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/C/2013/clincial-office-cough-signage.pdf

6. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): how to wash your hands [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/factsheet-covid-19-hand-hygiene.pdf?la=en

7. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): non-medical masks and face coverings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/2020/05/factsheet-covid-19-non-medical-masks.pdf?la=en

8. Alberta Health Services, COVID-19 Scientific Advisory Group. COVID-19 Scientific Advisory Group rapid evidence report. Topic: can people with previous COVID-19 infection become re-infected by the SARS-CoV-2 virus? [Internet]. Edmonton, AB: Alberta Health Services; 2020 [modified 2020 May 12; cited 2020 Jun 05]. Available from: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-reinfection-rapid-review.pdf

9. Ontario Agency for Health Protection and Promotion (Public Health Ontario). COVID-19 – What we know so far about…viral detection [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020

[cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/covid-wwksf/2020/05/what-we-know-viral-detection.pdf?la=en

10. Bullard J, Dust K, Funk D, Strong JE, Alexander D, Garnett L, et al. Predicting infectious SARS-CoV-2 from diagnostic samples. Clin Infect Dis. 2020 May 22 [Epub ahead of print]. Available from: https://doi.org/10.1093/cid/ciaa638

11. Wölfel R, Corman VM, Guggemos W, Seilmaier M, Zange S, Müller MA, et al. Virological assessment of hospitalized patients with COVID-2019. Nature. 2020;581(7809):465-9. Available from: https://doi.org/10.1038/s41586-020-2196-x

12. Ontario. Ministry of Health. COVID-19 quick reference public health guidance on testing and clearance [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_clearing_cases_guidance.pdf

13. van Doremalen N, Bushmaker T, Morris DH, Holbrook MG, Gamble A, Williamson BN, et al. Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. N Engl J Med. 2020;382(16):1564-7. Available from: https://doi.org/10.1056/nejmc2004973

14. Centers for Disease Control and Prevention. Hand sanitizer use out and about [Internet]. Atlanta, GA: Centers for Disease Control and Prevention; 2020 [cited 2020 Jun 05]. Available from: https://www.cdc.gov/handwashing/hand-sanitizer-use.html

15. Ontario. Ministry of Health. COVID-19 reference document for symptoms [Internet]. Version 6.0 – August 6, 2020. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_reference_doc_symptoms.pdf

16. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Removing personal protective equipment / putting on personal protective equipment [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/l/2013/lanyard-removing-putting-on-ppe.pdf?la=en

17. Government of Ontario. How Ontario is responding to COVID-19 [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.ontario.ca/page/how-ontario-is-responding-covid-19#section-2

18. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): physical distancing [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/factsheet-covid-19-guide-physical-distancing.pdf?la=en

19. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): droplet and contact precautions: non-acute care facilities [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ipac-additional-precautions-non-acute-care.pdf?la=en

20. Government of Canada. Non-medical masks and face coverings: about [Internet]. Ottawa, ON: Government of Canada; 2020 [cited 2020 Jun 05]. Available from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks/about-non-medical-masks-face-coverings.html#_Appropriate_non-medical_mask

21. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Risk algorithm to guide PPE use [Internet]. Toronto, ON: Queen's Printer for Ontario; 2013 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/c/2013/clinical-office-risk-algorithm-ppe.pdf?la=en

22. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Putting on full personal protective equipment: step-by-step demonstration of how to properly put on full personal protective equipment [video recording on the Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. 2 min. Available from: https://www.publichealthontario.ca/en/videos/ipac-fullppe-on

23. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Taking off full personal protective equipment: step-by-step demonstration of how to properly take off full personal protective equipment [video recording on the Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. 1 min. Available from: https://www.publichealthontario.ca/en/videos/ipac-fullppe-off

24. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Recommended steps: putting on personal protective equipment (PPE) [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ppe-recommended-steps.pdf?la=en

25. Ontario Agency for Health Protection and Promotion (Public Health Ontario). At a glance: infection prevention and control fundamentals [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ipac-fundamentals.pdf?la=en

26. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): cleaning and disinfection for public settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet-covid-19-environmental-cleaning.pdf?la=en

27. Salvadori M, Chung S, National Advisory Committee on Infection Prevention and Control (NAC-IPC); Public Health Agency of Canada Healthcare-Associated Infections Prevention and Control Section. Infection prevention and control for COVID-19: second interim guidance for acute healthcare settings. Ottawa, ON: Government of Canada; 2020 [modified 2020 May 19; cited 2020 Jun 05]. Available from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/infection-prevention-control-covid-19-second-interim-guidance.html#a12

28. BC Centre for Disease Control. Cleaning and disinfecting [Internet]. Vancouver, BC: Provincial Health Services Authority; 2020 [cited 2020 Jun 05]. Available from: http://www.bccdc.ca/health-info/diseases-conditions/covid-19/prevention-risks/cleaning-and-disinfecting

29. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Chlorine dilution calculator [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/en/health-topics/environmental-occupational-health/water-quality/chlorine-dilution-calculator

30. Ontario Agency for Health Protection and Promotion (Public Health Ontario). COVID-19 preparedness and prevention in congregate living settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 04]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/05/covid-19-preparedness-prevention-congregate-living-settings.pdf?la=en

31. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Managing COVID-19 outbreaks in congregate living settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 04]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/05/managing-covid-19-outbreaks-congregate-living-settings.pdf?la=en

32. Ontario. Ministry of Health. Public health unit locator [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.phdapps.health.gov.on.ca/phulocator/

33. Ontario Agency for Health Protection and Promotion (Public Health Ontario). At a glance: COVID-19: personal protective equipment (PPE) and non-medical masks in congregate living settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jul 20]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/covid-19-ppe-non-medical-masks-congregate-living-settings.pdf?la=en

34. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): when and how to wear a mask: recommendations for the general public [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/factsheet-covid-19-how-to-wear-mask.pdf?la=en

35. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): how to cohort during an outbreak of COVID-19 in a congregate living setting [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jul 20]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/factsheet-covid-19-outbreak-how-to-cohort-congregate-living-setting.pdf?la=en

36. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): mask use for non-healthcare workers [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jul 20]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/2020/05/factsheet-covid-19-masks-not-healthcare.pdf?la=en

37. Ontario Agency for Health Protection and Promotion (Public Health Ontario). IPAC recommendations for use of personal protective equipment for care of individuals with suspect or confirmed COVID-19 [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jul 20]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/updated-ipac-measures-covid-19.pdf?la=en

38. Government of Canada. COVID-19 medical masks and respirators: information for health professionals [Internet]. Ottawa, ON: Government of Canada; 2020 [modified 2020 Jun 26; cited 2020 Jul 20]. Available from: https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/masks-respirators-covid19/health-professionals.html#a2

39. Health Canada. Important regulatory considerations for the supply of medical gowns: guidance to industry [Internet]. Ottawa, ON: Government of Canada; 2020 [modified 2020 Jun 24; cited 2020 Jul 20]. Available from: https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/guidance-documents/covid19-medical-gowns.html#a3

40. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Focus on: cohorting in outbreaks in congregate living settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/focus-on-cohorting-outbreaks-congregate-living-settings.pdf?la=en

41. Ontario. Ministry of Health. COVID-19 fact sheet: resources for Ontarians experiencing mental health and addictions issues during the pandemic [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/resources_ontarians_experiencing_mha.pdf

42. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): take care of yourself and each other [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/factsheet-covid-19-guide-take-care-yourself-others.pdf?la=en

43. Government of Ontario. COVID-19: support for people [Internet]. Toronto, ON: Queen's Printer for Ontario: 2020 [cited 2020 Jun 05]. Available from: https://www.ontario.ca/page/covid-19-support-people#mental-health

44. Public Health Agency of Canada. Trauma and violence-informed approaches to policy and practice [Internet]. Ottawa, ON: Government of Ontario; 2018 [modified 2020 Feb 02; cited 2020 Jun 05]. Available from: https://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html

45. Canadian Public Health Association; Centre for Sexuality. Trauma- and violence- informed care toolkit for reducing stigma related to sexually transmitted and blood-borne infections (STBBIs) [Internet]. Ottawa, ON: Canadian Public Health Association & Centre for Sexuality; 2020 [cited 2020 Jun 05]. Available from: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/STBBI-TVIC-toolkit_e.pdf

46. Centre of Excellence for Women's Health. Publications: trauma, violence & mental health [Internet]. Vancouver, BC: Centre of Excellence for Women's Health; 2020 [cited 2020 Jun 05]. Available from: http://bccewh.bc.ca/category/post/trauma-violence-mental-health/

47. Government of Ontario. COVID-19 [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://covid-19.ontario.ca/

48. Ontario Agency for Health Protection and Promotion (Public Health Ontario). COVID-19 public resources [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/public-resources

49. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): you were tested for COVID-19: what you should know [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet/2020/06/factsheet-covid-19-test-what-you-should-know.pdf?la=en

50. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): how to self-monitor [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet-covid-19-self-monitor.pdf?la=en

51. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Coronavirus disease 2019 (COVID-19): how to self-isolate [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet-covid-19-how-to-self-isolate.pdf?la=en

52. Ontario. Ministry of Health. COVID-19 provincial testing guidance update [Internet]. Version 7.1. Toronto, ON: Queen's Printer for Ontario; 2020 [modified 2020 Aug 14; cited 2020 Aug 20]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_guidance.pdf

53. Government of Ontario. COVID-19 test results [Internet]. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 Jun 05]. Available from: https://covid19results.ehealthontario.ca:4443/agree

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