Prince Edward Island
CANADA
Health and Wellness

Prince Edward Island Guidelines for Infection Prevention and Control of COVID-19 in Long Term Care and Community Care Facilities

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Department of Health and Wellness
Chief Public Health Office

Contents

Executive Summary

This document provides foundational guidance specific to the COVID-19 pandemic in long term care facilities (LTCFs) and community care facilities (CCFs).

Individuals responsible for policy development, implementation and oversight of infection prevention and control (IPC) measures at specific LTCFs and CCFs should be familiar with relevant infection prevention and control background documents on routine practices and additional precautions and occupational health and safety legislation. The term "staff" is intended to include anyone working in LTC or CC having interactions with residents, including but not limited to health care workers. The term "visitor" is intended to include anyone who is not employed directly by the LTC or CC home but has been permitted entry into the facility.

Important measures to prevent introduction and spread of COVID-19 in LTC and CC:

- All staff must be trained on infection control measures **such as Routine Practices**, including proper hand hygiene (Appendix A), point-of-care risk assessment (PCRA) (Appendix B) and the importance of maintaining a 2 metre spatial distance between resident cohorts.
- All staff must work to identify suspect or confirmed cases of COVID-19 as early as possible in staff or residents.
- **Symptoms in elderly residents may be subtle or atypical, and staff who are screening residents should be sensitive to detection of changes from resident baseline physical and cognitive status.**
- All staff will use Droplet and Contact Precautions, in addition to Routine Practices, for all care of residents with suspected or confirmed COVID-19.
- **Staff will wear 2 medical masks layered or a fit checked or tested N95 respirator (Appendix C) when providing care of residents suspected or confirmed COVID-19.**
- **Staff will wear eye protection that is either a full face shield that covers the front and sides of the face or well-fitting goggles when providing care of residents suspected or confirmed COVID-19.**
- Facility management must identify all staff who work in more than one location (e. g. other LTC facilities, acute care and/or community care) and ensure efforts are made to prevent this *where possible,* to limit spread between facilities and to inform investigations during an outbreak. If this is not possible:
    - **Staff may work in LTC and a second LTCF if the staff member follows all testing and infection prevention and control measures as required by the Chief Public Health Officer.**
- COVID-19 immunization of staff and residents is supported by facility administration. Reporting of vaccination rates for staff and residents of Long Term Care and Community Care on PEI will be completed and submitted as directed.
- Visitation policies are in place to reduce the risk of introduction and transmission of COVID-19. Visitors will be admitted for compassionate reasons (e.g. end of life). Visitor restrictions are reassessed and adjusted according to the epidemiology of COVID 19 in the community.

Background

In December 2019, a cluster of cases of pneumonia of unknown origin was reported from Wuhan, Hubei Province in China. On January 10, 2020, a novel coronavirus, that causes a disease now referred to as COVID-19 was identified as the cause of this cluster of pneumonia cases. A global pandemic was declared on March 11, 2020.

COVID-19 is a virus belonging to the family of Coronaviruses. Illness can be mild like the common cold but can also be more severe including pneumonia and death. Current evidence indicates that our long term care population is at increased risk due to advanced age, chronic health conditions and the ease of transmission among the institution's environment.

Long term care facility residents are vulnerable to infection with COVID-19 due to behavioral factors, shared spaces, and transit to other healthcare facilities. Older adults and those with pre-existing medical conditions are also at risk for more severe disease and have higher mortality when infected with COVID-19.

Introduction

Infection prevention and control (IPC) strategies to prevent or limit transmission of COVID-19 in LTC and CC are similar to those used for the IPC of other acute respiratory infections, including:

- Prompt identification and isolation of all persons with signs and symptoms of possible COVID-19.
- Signs or symptoms may include:
    - Fever[1] Single **temperature equal to or > 38°c or feeling feverish**
    - Any new or worsening respiratory symptoms (cough, shortness of breath or **difficulty breathing**, runny nose or sneezing, nasal congestion, sore throat or difficulty swallowing) OR
    - Any new onset non-respiratory symptoms including chills, muscle or body aches, fatigue or weakness, gastrointestinal symptoms (abdominal pain, diarrhea, vomiting), headache, new loss of taste or smell or other unexplained symptoms or change in clinical status.

Infection Prevention and Control (IPC) Measures

In order to prevent disease spread in LTC facilities, staff must receive ongoing training, testing and monitoring of compliance with Routine Practices, including hand hygiene, and implementation of Additional Precautions, including Droplet and Contact Precautions. Policies and procedures must be in place to reduce the introduction and control the spread of COVID-19.

Routine Practices

Routine practices apply **to all staff, residents and visitors**, **at all times, in all LTC facilities** and include but are not limited to:

- Conducting a point of care risk assessment (PCRA)
- Hand hygiene
- Appropriate use of Personal Protective Equipment (PPE)
- Adhering to respiratory hygiene (i.e., covering a cough with a tissue or coughing into elbow followed by performing hand hygiene)

[1] Difficulties in measuring temperature may result in low temperature readings in some cases in which fever is actually present.

Point-of-Care Risk Assessment (PCRA)

Prior to any resident interaction, all staff should assess the infectious risks posed to themselves, other staff, residents, and visitors during a care situation or procedure.

- The PCRA **(Appendix B)** helps staff to select the appropriate actions and/or PPE to minimize risk of exposure to known and unknown infections.
- Performing a PCRA helps to avoid misuse of PPE.

Hand Hygiene

Staff is required to perform hand hygiene (Appendix A):

- On entry to and exit from the LTC and CC facility
- Before and after contact with a resident, regardless of whether gloves are worn
- Before preparing or administering all medications or food
- Before performing aseptic procedures
- Before putting on PPE and during removal of PPE according to facility procedure for putting on or removing PPE
- Before putting gloves on
- Before and after contact with the resident's environment (e.g. medical equipment, bed, table, door handle) regardless of whether gloves are worn
- After removing gloves
- Any other time hands are considered to be potentially contaminated (e.g. after handling blood, body fluids, bedpans, urinals, or wound dressings)
- After other personal hygiene practices (e.g. blowing nose, touching face, using toilet facilities, etc.)

Residents should perform hand hygiene:

- Upon entering or leaving their room
- Prior to eating, oral care, or handling of oral medications
- After using toileting facilities
- Any time hands are considered to be potentially contaminated (e.g. after handling blood, body fluids, bedpans, urinals, or wound dressings)

Hands may be cleaned using alcohol-based-hand-rub (ABHR) containing 60-90% alcohol, or plain liquid soap and water. Washing with soap and water is preferable for use immediately after using toilet facilities, if hands are visibly soiled or when caring for a resident with diarrhea.

Droplet Contact Precautions

- Droplet and contact precautions must be implemented for all residents who are considered exposed to, diagnosed with, or presenting with signs or symptoms of COVID-19. Donning and Doffing of PPE is described in **Appendix D.**
- Gloves, a long-sleeved cuffed gown (covering front of body from neck to mid-thigh), two medical grade-masks layered or a fit checked or tested N95 respirator and face or eye protection should be worn upon entering the resident's room or when within 2 metres of the resident on droplet and contact precautions.

- **Examples of face or eye protection include full face shield that covers the front and sides of the face or well-fitting goggles; regular eyeglasses or safety glasses with gaps between glasses and the face are not sufficient protection.**

- The area where PPE is donned should be separated as much as possible from the area where it is removed and discarded.
- Hand hygiene must be performed prior to putting on or removing PPE.

IPC Preparedness for COVID-19

LTC and CCF Operators must ensure:

- Generation of a list of staff that work at more than one health care facility and ensure that staff are tested per current guidance.
- A current and up to date staff list with contact numbers is available in the event of an outbreak.
- Facilities should maintain a contact-tracing record each day for each resident to include all contacts with other persons by a resident including partners in care, Designated Visitors, or any contacts in an exceptional life circumstance.
- **Aerosol-generating medical procedures (AGMPs)[2] are only performed if deemed medically necessary for residents suspected or confirmed COVID-19 or when facility is in a COVID-19 outbreak.**
  - If AGMPs are performed,
    - There is appropriate training and N95 respirator fit-testing/fit checking **(Appendix C)** for all staff who may be required to participate in or who may be exposed to these procedures
    - The fewest staff necessary to perform the procedure are present
    - Entry into a room of a resident undergoing CPAP should be minimized
    - These procedures are performed in a single room with the door closed
- Advance directives for all residents are reviewed.
- Visitor restriction is in place in accordance with current guidance and a plan to facilitate visitation safely is developed.
- Appropriate number and placement of alcohol-based hand rub (ABHR) dispensers to allow easy access throughout the facility and at point of care.
- Environmental cleaning and disinfection practices are monitored for compliance.
- Heating, ventilation and air conditioning systems are properly installed and regularly inspected and maintained.
- **Residents considered exposed to, suspected or confirmed to have COVID-19 are placed immediately on Droplet and Contact Precautions until COVID-19 or other infectious respiratory illness is ruled out, and until criteria for discontinuation of Additional Precautions are met.**

[2] Aerosol-generating medical procedure includes: cardio-pulmonary resuscitation, sputum induction, nebulization, non-invasive positive pressure ventilation (CPAP, BiPAP), or open suctioning

- **A resident who is suspected or confirmed to have COVID-19, or who is a close contact of a person confirmed to have COVID-19, should be cared for in a single room with a toilet and sink designated for their use.**
- **Residents who are confirmed to have COVID-19 (and not other healthcare-associated pathogens) may be cohorted in separate adequately ventilated units or areas. Wherever possible, staff should be dedicated to caring for these residents, in effort to reduce the risk of transmitting infection in the facility.**
- **Roommates of symptomatic residents should not be moved to new shared rooms but be placed in a single room for isolation and monitoring for signs and symptoms.**
- Staff uniforms are promptly removed and laundered after their work shift.
- Waste and soiled linen are managed and/or adequately cleaned and disinfected according to LTC and CCF policies and procedures.
- The care environment is cleaned using an enhanced cleaning protocol with an emphasis on frequently touched surfaces.

LTC and CCF Staff must ensure:

- Adherence to LTC and CCF IPC policies and procedures and public health guidance.
    - Self-monitoring for symptoms of COVID-19 is done daily, report any new symptoms to the LTC or CC facility and arrange for testing. If symptoms occur at work immediately perform hand hygiene, don a medical grade mask, inform the supervisor, leave as soon as it is safe to do so and arrange testing.
- If staff have a potential exposure to a case of COVID-19 they must report to LTC or CCF management to determine whether work restrictions are necessary.
- Staff are knowledgeable about:
    - Routine practices are adhered to for all resident interactions, e.g. hand hygiene, point of care risk assessment.
    - How to conduct a point-of-care risk assessment **(Appendix B)** prior to interactions to determine what IPC measures are needed to protect residents and themselves from infection.
    - The proper use of available PPE.
    - Procedure to safely don and doff PPE. **(Appendix D)**
    - Who to test if residents become symptomatic or if requested by local public health authorities, the LTC or CC facility.

Screening

Access to the LTC or CC facility should continue to be monitored.

- Visitor restrictions will be reassessed throughout and adjusted according to the epidemiology of COVID 19 in the community.
- Essential service visitors to the facility should be those who are necessary to maintain functioning of the facility e.g. food delivery, supplies, funeral director etc.

- Family and visitors will be admitted for compassionate reasons (e.g. end of life).
- Anyone entering the facility should screen for COVID-19 symptoms prior to entering and must not enter if experiencing or displaying symptoms.
- All staff and visitors should perform hand hygiene upon entry to facility.
- Physical distancing of 6 ft/2 meters should be maintained between visitors and other residents.
- Movement should be limited within the facility to directly visiting the resident and exiting the LTC or CCF after their visit.
- If the visitor is unable to adhere to appropriate precautions, the visitor will be excluded from visiting.
- Food and essential items should be delivered through a single access point. Consideration should be made to avoid unnecessary entry into LTC or CCF, and if entry is required, delivery personnel should screen for illness as per other visitors.
- Masks, tissues, ABHR and a no-touch waste receptacle should be available for staff, residents, and visitors' use at the screening point at each entrance.

Resident and Staff Screening and Management

LTC and CC facilities must ensure that there are processes in place to conduct active screening of staff and residents for signs and symptoms of COVID-19.

Staff

- Staff will self-monitor for signs or symptoms of COVID-19 daily and immediately report any new symptoms to facility management, and refrain from working with signs or symptoms of COVID-19.
- Staff should be restricted in work assignments to specific units/**cohorts** wherever feasible, to limit the spread within facilities.
- All staff working in more than one LTC facility, when one facility is in a COVID-19 outbreak should be tested for COVID-19 weekly.
- If a staff member develops symptoms of COVID-19 at work they should immediately perform hand hygiene, don a medical grade mask, inform their supervisor, avoid further resident contact if safe to do so, leave as soon as it is safe to do so and arrange testing.
- Symptomatic staff should access testing:
    - If the test results are negative for COVID-19 but the employee remains ill/symptomatic, they should not return to work until well.
    - If the test results are negative for COVID-19 and the employee is no longer ill/symptomatic, the employee can return to work.
- **If the test results are positive for COVID-19 the employee follows the direction of Public Health and self-isolates as per the direction of CPHO guidelines.**

Residents

- Test residents
    - Prior to admission to the facility (24 hours) regardless of symptoms.
    - Follow up testing schedule as outlined in the current Testing Memo.

- **Residents with a history of COVID-19 infection, within the previous 90 days, should not be tested. Assess for symptoms.**

- Resident screening should include regular and thorough assessments for signs and symptoms of COVID-19, assessments should occur at minimum daily.
- Symptoms in elderly residents may be subtle or atypical, and staff who are screening residents should be sensitive to detection of changes from resident baseline physical and cognitive status.
- Considerations for older adults include:
    - **Fever may be defined as temperature 37.8 °c or greater; repeated temperatures > 37.2 °c or an increase in temperature of > 1.1 °c over baseline may represent fever in older adults, and fever may be absent.**
    - **New and unexplained symptoms may include but not limited to chest pain, dizziness, loss of appetite, lethargy, or changes in cognition.**
    - **Older adults may be more likely to present with atypical signs and symptoms (e.g., increased frequency of falls, delirium)**
    - **Individuals with cognitive impairment who may not be able to describe COVID-19 symptoms may present with refusal of food and drink or an abrupt change in mental status, functional status, or behavior**
- A resident who displays signs or symptoms of COVID-19 should immediately be placed on droplet/contact precautions and tested.
- **Roommates of symptomatic residents should not be moved to new shared rooms but be placed in a single room for isolation and monitoring for signs and symptoms.**
- If the resident was tested due to being symptomatic for COVID 19 and remains symptomatic after an initial negative result, **retesting may be done 2 to 4 days after the initial test**. The resident will remain on precautions as appropriate until no longer symptomatic.
- Staff should initiate and maintain a line listing of residents **(Appendix E)** with suspected or confirmed COVID-19

Outbreak Management

A suspect outbreak is defined as a single laboratory-confirmed case of COVID-19 in a resident or staff member in a long term care (LTC) or community care (CC) facility.

Confirmed outbreak in a facility is defined as two or more lab-confirmed COVID-19 cases in residents or staff in a facility with an epidemiological link, within a 10-day period, where at least one case could have reasonably acquired their infection in the facility.

COVID-19 Outbreak Protocol

Precautions should be taken to prevent the introduction of illness into LTC and CC facilities.

Two main priorities will determine the size and duration of the outbreak, early detection (testing) and implementation of outbreak measures.

Residents

- Residents with suspected or confirmed COVID-19 will be placed on contact and droplet precautions.
- Residents diagnosed with COVID-19 should be placed on contact and droplet precautions for 10 days following the symptom onset date (whether vaccinated or unvaccinated).
- Precautions should remain in place for 10 days and until resolution of fever for 24 hours without fever reducing medication and symptoms have improved.
- Once an outbreak is established, any residents with symptoms should be managed as suspect cases and until test results have been reported
- Residents who are immunocompromised require 14 days of contact and droplet precautions.

Resident Contacts

- Roommates, dining table mates and other residents with significant contact will be identified as close contacts and will be placed on contact and droplet precautions.
- Close contacts will be placed on contact and droplet precautions for a minimum of 4 days.
- Contact and droplet precautions can be discontinued at day 4 if asymptomatic and day 4 test is negative.
- **Close contacts will be tested at day 0, 4 and day 6. If symptomatic test immediately and do not wait for next testing day.**
- Other contacts within the facility do not need to be placed on contact and droplet precautions unless determined to have significant close contact with the case.

Aerosol-generating medical procedures (AGMPs)[3]

An AGMP is any procedure conducted on a resident that can induce production of aerosols of various sizes, including droplet nuclei.

Consider discontinuing CPAP/BiPAP during an outbreak in consultation with the physician/NP.

AGMPs on a resident suspected or confirmed to have COVID-19 should be avoided if possible and only be performed if:

- The AGMP is medically necessary and performed by the most experienced person
- The minimum number of persons required to safely perform the procedure are present
- All persons in the room are wearing a fit-tested and/or fit-checked **(Appendix C)**, N95 respirator, gloves, gown and face or eye protection
- The door of the room is closed

Specimen Collection

Nasopharyngeal (NP) or nasal and throat swabs should be collected by qualified staff who are knowledgeable about proper collection methods.

- During sample collection, staff should be limited to those necessary for resident care during the procedures.
- All staff in the room during collection should wear PPE in accordance with contact and droplet precautions.

[3] Aerosol-generating medical procedure includes: cardio-pulmonary resuscitation, sputum induction, nebulization, non-invasive positive pressure ventilation (CPAP, BiPAP), or open suction

Handling Lab Specimens

All specimens collected for laboratory investigations should be regarded as potentially infectious and placed in biohazard bags. Handle as per Routine Practices.

Implementation of Control Measures

Immediately report and discuss the suspected outbreak with the Chief Public Health Officer (CPHO) or designate.

During an Outbreak all outbreak control measures take priority over routine operations until the outbreak is declared over.

Infection Prevention and Control

Facility

- Post outbreak notification sign(s) at facility entrance and/or floor/unit/household advising about the outbreak.
- Maintain an outbreak line list (**Appendix E**) of cases in residents and a line list of cases in staff (nursing, food handlers, housekeeping, etc.) and forward to the CPHO daily.
- Close the affected floor/unit/household or facility to new admissions, readmissions, or transfers unless necessary.

Environmental Cleaning and Disinfection

Cleaning and disinfection of high-touch surfaces is important for controlling the spread of microorganisms.

- Environmental disinfectants should be classed as a hospital grade disinfectant **registered in Canada with a Drug Identification Number (DIN) and labelled as effective for both enveloped and non-enveloped viruses.**
- In the event that commercially-prepared hospital disinfectants are not available, diluted bleach solution may be used to disinfect the environment.
    - **The minimum concentration of chlorine should be 1000 ppm or 0.1% (equivalent to a 1:50 dilution of 5% concentrated liquid bleach). When using bleach, cleaning must precede disinfection.**
- All surfaces, that are considered **"frequently touched"** (e.g. telephone, bedside table, overbed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet handles, shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser, dining tables, etc.) should be cleaned and disinfected at **a minimum of twice daily and when soiled**.
- Resident care equipment (e.g., BP cuffs, electronic thermometers, oximeters, stethoscope) should be cleaned and disinfected after each use and between residents with hospital-grade disinfectant following the recommended contact time.
- **Room cleaning and disinfection** should be performed at least **once per day on all low touch surfaces** (e.g., shelves, bedside chairs, windowsills, overbed light fixtures, etc.). Floors and walls should be kept visibly clean and free of spills, dust and debris.
- All surfaces or items, **outside of the resident room, that are touched by or in contact with staff** (e.g., computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) should be cleaned and disinfected **at least daily and when soiled**. Staff should ensure that hands are cleaned before touching shared equipment.

- **Environmental services staff should wear the same PPE as other staff when cleaning and disinfecting the resident's room.**

- Facility protocol for cleaning of the resident's room after discharge, transfer, or discontinuation of Droplet and Contact Precautions should be followed. Toilet brushes, unused toilet paper and other disposable supplies should be discarded, and all bedside privacy curtains removed and laundered at the time of resident discharge or transfer.

Resident Care Equipment

- All reusable equipment and supplies, electronics, personal belongings, etc., should be dedicated to the use of the resident with suspect or confirmed COVID-19 infection. If use with other residents is necessary, the equipment and supplies should be cleaned and disinfected with a hospital-grade disinfectant, ensuring adequate contact time before reuse. Items that cannot be appropriately cleaned and disinfected should be discarded.

Linen, Dishes and Cutlery

- No special precautions are recommended; routine practices are used.

Waste Management

- No special precautions are recommended; routine practices are used.

Resident Admissions and Transfers

- If an admission or transfer is deemed necessary, consideration can be made on a case-by-case basis, discuss with Infection Prevention and Control (IPC) or the CPHO for guidance.

Considerations include:

- Current status of outbreak and management (length of time since last case, attack rate, severity of illness)
- Is the area of the facility that the resident is returning to experiencing the outbreak or have cases of COVID-19 in the resident population
- Immunization status of the resident
- Have the resident /substitute decision maker and most responsible provider/physician been informed of the outbreak and consented to the move.
- The overall benefit vs. risk to the health of the transferring client of immediate vs. delayed placement in the facility.
- Residents without a COVID-19 diagnosis should not be admitted or moved to a room occupied by a case during the infectious period, unless the resident to be moved has recently recovered from COVID-19.
- Where transfers are medically necessary (hospital admission) or for urgent/medically necessary appointments (dialysis), the receiving facility/unit and transporting personnel must be notified of the outbreak and of any additional precautions the resident requires. Notify the receiving hospital or clinic to ensure that care can be provided safely.
- Residents should be provided with clean attire, be accompanied by staff, wear a mask, be instructed to perform hand hygiene (with assistance as necessary).
- Wheelchairs or transport stretchers should be cleaned and disinfected prior to exiting the resident's room and after being used. Any surfaces outside the resident's room that the resident may have touched should be cleaned and disinfected

- Droplet and contact precautions should be maintained by staff during resident transport, and the need for droplet and contact precautions should be communicated to the transferring service and receiving unit ahead of transfer.

- If a resident is transferred to an acute care facility for treatment or complications of COVID-19, they may return to the outbreak facility when medically stable.
- Residents transferred to an acute care facility who do not have COVID-19 should not be transferred back to a COVID affected part of the facility.
- Notify any facility that you transferred a resident to within the past 10 days, that your facility has a COVID-19 outbreak.

Staff allocation

- **Staff should be dedicated to working in one LTC facility.**
- All staff working in more than one LTC facility, when one facility is in a COVID-19 outbreak should be tested for COVID-19 weekly using a molecular based testing method (ID NOW)
- Cohort staff when possible e.g. staff working with symptomatic residents should avoid working with residents who are well.
- If dedicated staff for ill residents is not available, staff should first work with the well residents, then move on to care for ill residents. Movement between floor, units and cohorts should be avoided where possible.
- Staff who have recovered from COVID-19 may work and should be prioritized to work in facilities experiencing an outbreak or COVID-19 units.

Group Activities

- Includes communal dining, recreational activities, group entertainment.
- Are suspended during an outbreak
- If outbreak is contained to one section of a facility, consideration can be made to resume group activities for remainder of facility following all infection control precautions.
- Residents with suspected or confirmed COVID-19 or who are close contacts of cases and require contact and droplet precautions must not participate in communal dining or group activities.
- Residents who have recovered from COVID-19 may resume participation in group activities and communal dining.

Declaring the Outbreak Over

The outbreak may be considered over when **no new cases in residents or staff in the facility with an epidemiological link are identified for at least 10** days in consultation with the CPHO.

Control measures will be continued until the outbreak is declared over.

Discontinuing Additional Precautions

The duration and discontinuation of contact and droplet precautions for an individual resident or unit/household on outbreak should be determined on a case-by-case basis, if needed consultation with Infection Prevention and Control (IPC) or the CPHO.

Handling of Deceased Bodies

Routine practices should be used properly and consistently when handling deceased bodies or preparing bodies for autopsy or transfer to mortuary services.

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Appendix A - Hand Hygiene

Your 4 Moments for Hand Hygiene

Appendix B - Point of Care Risk Assessment Tool for COVID-19

Prior to any patient interaction, all health care workers (HCWs) have a responsibility to always assess the infectious risk posed to themselves and to other patients, visitors, and HCWs. This risk assessment is based on professional judgement about the clinical situation and up-to-date information on how the specific healthcare organization has designed and implemented engineering and administrative controls, along with the availability and use of Personal Protective Equipment (PPE).

Point of Care Risk Assessment (PCRA) is an activity performed by the HCW before every patient interaction, to:

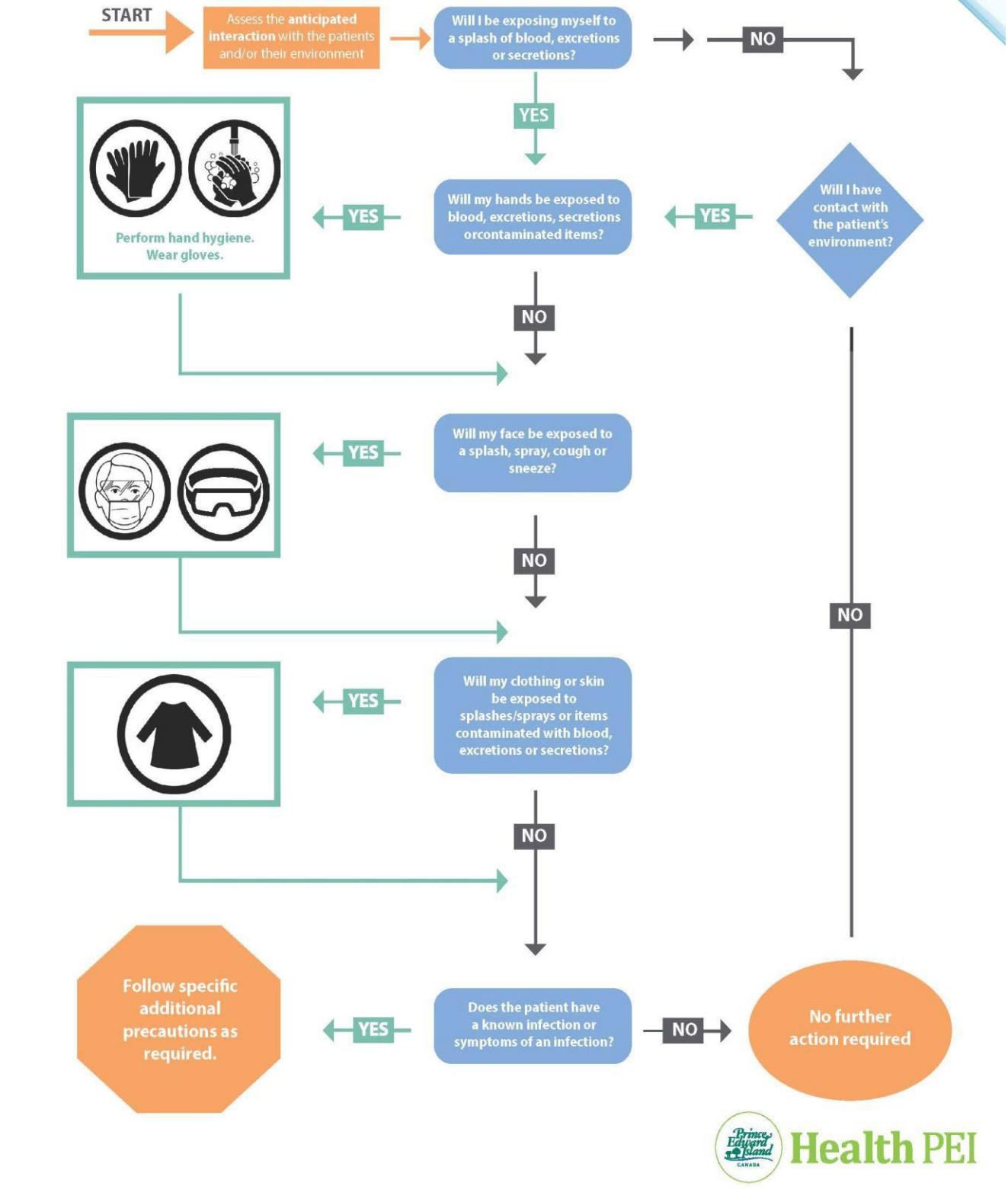
1. Evaluate the likelihood of exposure to COVID-19,
    a. from a **specific interaction** (e.g., performing/ assisting with clinical procedures/ interaction), non-clinical interaction (i.e., admitting, teaching patient/ family), transporting patients, direct face-to-face interaction with patients, etc.)
    b. with a **specific patient** (e.g., residents not capable of self-care/ hand hygiene, have poor-compliance with respiratory hygiene, copious respiratory secretions, frequent cough/ sneeze, early stage of illness, etc.)
    c. **specific environment** (e.g., single rooms, shared rooms/ washrooms, hallway, assessment areas, emergency departments, public areas, therapeutic departments, diagnostic imaging departments, housekeeping, etc.)

AND

2. Choose the appropriate actions/ PPE needed to minimize the risk of patient, HCW/other staff, visitor, contractor, etc. exposure to COVID-19

PCRA is not a new concept, but one that is already performed regularly by professional HCWs many times a day for their safety and the safety of patients and others in the healthcare environment. For example, when a HCW evaluates a patient and situation to determine the possibility of blood or body fluid exposure or chooses appropriate PPE to care for a patient with an infectious disease, these actions are both activities of a PCRA.

Routine Practices Risk Assessment + Algorithm for all Patient Interactions



Appendix C - How to Fit-Check a N95 Mask

Fit checking involves a quick check - each time the mask is put on - to ensure that the respirator is properly applied, that a good seal is achieved over the bridge of the nose and mouth and there are no gaps between the respirator and face. Fit checking is the appropriate minimum standard at the point of use for healthcare workers using N95 respirators.
No clinical activity should be undertaken until a satisfactory fit has been achieved.

Instructions to fit check a N95 mask;

3. Place the respirator on your face.
4. Place the headband or ties over your head and at the base of your neck.
5. Compress the respirator to ensure a seal across your face, cheeks and the bridge of your nose.
6. Check the positive pressure seal of the respirator by gently exhaling. If air escapes, the respirator needs to be adjusted.
7. Check the negative pressure seal of the respirator by gently inhaling. If the respirator is not drawn in towards your face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.

Appendix D - Donning and Doffing PPE

Contact and Droplet Precautions

Suspected or Confirmed Resident with Respiratory Illness (Influenza-like Illness, Influenza, COVID-19) follow Contact/ Droplet Precautions. This includes the appropriate selection and use all of the following personal protective equipment (PPE).

- Gloves
- Long-sleeved gown
- Facial protection, such as a surgical/procedure mask and eye protection/ face shield, or surgical/procedure mask with visor attachment

All PPE should be removed before leaving the patient's room and discarded into a no-touch receptacle.

Donning PPE Order

1. Perform hand hygiene
2. Don gown
3. Apply mask
4. Apply face shield or goggles
5. Put on gloves

Doffing PPE Order

1. Remove gown and gloves (can be removed together)
2. Perform hand hygiene
3. Remove face shield or goggles (do not touch the front)
4. If appropriate remove mask touching only the strings or ear loops.
5. Perform hand hygiene

Appendix E - Line List Information on Residents and Staff with Symptoms of COVID-19

Facility: ________________________________ Date: ________________________

RESIDENTS: Total Number of Residents:			**Number of Residents ill:**				
Name	**Onset Date**	**Unit**	**Symptoms**		**MRN**	**Swabbed If Yes, Date**	**Comments**
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**		**Date** **Y or N**	
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**________		**Date** **Y or N**	
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**________		**Date** **Y or N**	
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**________		**Date** **Y or N**	
STAFF: Total Number of Staff: ____________			**Number of Staff ill:**				
Name	**Onset Date**	**Last Date of Work**	**Symptoms[4]**		**MRN**	**Swabbed If yes, Date**	**Comments**
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**________		**Date** **Y or N**	
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**________		**Date** **Y or N**	
			☐ **Fever[4]** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other[5]**________		**Date** **Y or N**	
			☐ **Fever** ☐ **Muscle/body aches** ☐ **Headache**	☐ **Sudden onset cough** ☐ **Sore Throat** ☐ **Other**		**Date** **Y or N**	

[4] Fever Single temp >37.8°C

[5] Any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), OR Any new onset non-respiratory symptoms including chills, muscle aches, diarrhea, malaise, headache, sudden loss of taste or smell or other unexplained symptoms or change in clinical status.