

IPAC MANUAL FOR SHELTER SETTINGS

Practice Health Check

Adapted from "Infection Prevention and Control Guide for Homelessness Service Settings" | Toronto Public Health (2019)

ABOUT THIS GUIDANCE DOCUMENT

This guidance document was adapted from the Infection Prevention and Control Guide for Homelessness Service Settings (2019) compiled by Toronto Public Health (TPH) and is a collection of evidence-based practice recommendations from expert groups in infection prevention and control (IPAC) across North America.

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DEFINITIONS

ALCOHOL-BASED HAND RUB (ABHR): Also known as hand sanitizer. This is a liquid, gel or foam formula that contains alcohol which is used to reduce the number of germs on hands in situations when the hands are not visibly soiled.

BODY SUBSTANCES: Includes blood, and body fluids (e.g., excretions such as urine, feces, vomit; secretions such as semen, saliva).

CLEANING: The physical removal of debris and organic material (such as dust, soil, blood, feces). Cleaning physically removes rather than kills germs. This is done with water, detergents, and mechanical action (e.g., friction and rubbing).

CLIENT: Any individual who utilizes services provided by a homelessness service setting.

CONTACT TIME: The amount of time that a disinfectant needs to be wet on a surface for it to be effective against the types of germs listed on its label.

CONTAMINATION: The presence of germs on hands or on surfaces (e.g., clothing, personal protective equipment, environmental surfaces, bedding, toys, dressings).

CROSS-CONTAMINATION: Cross-contamination refers to the transfer of germs from a dirty source to a clean source.

DISINFECTANT: A chemical product that is used on surfaces for the purposes of killing germs.

DISINFECTION: The process of using chemicals or heat to kill most germs on environmental surfaces/inanimate objects.

GASTROINTESTINAL ILLNESS: Illness generally characterized with symptoms such as diarrhea, vomiting, nausea, abdominal pain, abdominal cramping.

GERM: Also known as a microorganism or infectious agent. A germ is capable of causing an infection (e.g., a bacterium, fungus, parasite, virus or prion).

HAND HYGIENE: Refers to hand cleaning. Hand hygiene may be accomplished using soap and warm running water or ABHR.

HAND WASHING: The physical removal of germs from the hands using soap and warm running water.

HOMELESSNESS SERVICE SETTING: A setting that provides shelter and services to clients experiencing homelessness.

HOMELESSNESS SERVICE SETTING PROVIDER: Homelessness service setting operators/management. This can also be operators for a not-for-profit organization that provides shelter services.

HOMELESSNESS SERVICE SETTING WORKER: Any workers, agency workers or volunteers in a homelessness service setting.

INFECTION: The entry and growth of a germ in host. May or may not cause clinical symptoms.

INFECTION PREVENTION AND CONTROL (IPAC): Evidence-based practices and procedures that, when applied consistently, can prevent or reduce the risk of infection.

MUCOUS MEMBRANES: Body tissue lining that is rich in mucous glands such as the mouth, eyes and nose.

NON-INTACT SKIN: This refers to a break in the skin (e.g., wound).

PERSONAL PROTECTIVE EQUIPMENT (PPE): Clothing or equipment worn for protection against hazards (e.g., gloves, gowns, masks).

RESPIRATORY ETIQUETTE: Personal practices (e.g., covering the mouth when coughing, care when disposing of tissues) that help prevent the spread of germs that cause respiratory illness.

RISK ASSESSMENT: The evaluation of the interaction between a worker and a client/the environment to analyze the risk of exposure to germs.

REPROCESSING: The steps performed (e.g., cleaning, disinfection, sterilization) to prepare used medical equipment (e.g., goggles) for use.

ROUTINE PRACTICES: The system of infection prevention and control practices to be used at all times with all clients to prevent and control transmission of germs.

SHARPS: Objects capable of causing punctures or cuts (e.g., needles, blades, glass).

SURVEILLANCE: The process of collecting and analyzing symptoms of clients and workers over a period of time.

IPAC MANUAL FOR SHELTER SETTINGS

Infection Prevention and Control is the use of evidence-based practices and procedures that when applied consistently, can help prevent or reduce the spread of germs.¹ The objective of this document is to provide guidance on IPAC principles and standards of practice for shelter providers, leadership, and workers.

1.0 ROUTINE PRACTICES

Routine practices are the system of IPAC practices recommended to be used at all times to prevent and control the spread of germs.⁴

The basic elements of routine practices include¹:

- Performing a risk assessment
- Hand hygiene
- Use of personal protective equipment (PPE) (e.g., gloves, gowns, facial protection)
- Control of the environment/environmental cleaning
- Supporting good IPAC practices (administrative controls)

While the concept of routine practices is most usually applied to healthcare settings, workers and providers in homelessness settings should still apply the general principles of routine practices in their daily activities to reduce the spread of germs.

Routine practices are based on the idea that people can potentially spread germs that can cause infections even when they do not have symptoms. With that said, consider all body substances (e.g., blood, body fluids), mucous membranes of the eyes, nose and mouth, non-intact skin or items soiled with body substances as potentially infectious.⁵⁸ Engaging in common IPAC practices and having safe standards of practice in place can help prevent exposure to germs.⁵ The remainder of this section will focus on the elements of routine practices.

1.1 RISK ASSESSMENT

A risk assessment is an evaluation of the interaction between a worker and a client/the environment to analyze the risk of exposure to germs.¹ Homelessness service setting workers are encouraged to perform a risk assessment before each client interaction and interaction with the environment to help prevent acquiring or transmitting germs.¹

Where there is a risk of exposure to germs based on a risk assessment, workers should use protective techniques or appropriate PPE (e.g., gloves, gown, or facial protection) to protect themselves and others.¹

Think of the following questions when performing a risk assessment:

- Does the client have symptoms of an infection (e.g., coughing, diarrhea, vomiting, a rash, a draining wound)?⁶
- Has the client been diagnosed with an infection?⁶

- What kind of contact or activity will you be doing with the client? ⁶
- Is there a risk of exposure to body substances, non-intact skin or mucus membranes of the eyes, nose or mouth and where on your body might you be exposed? ⁶
- What kind of personal protective equipment (PPE) is available on site?
- If you do not have the PPE available on your site, what other things can you do to decrease your risk of exposure to body substances, non-intact skin, mucous membranes of the eyes, nose or mouth?
- What is your immune status (e.g., are routine immunizations up to date)? ¹

1.2 HAND HYGIENE

Hand hygiene is the most important and effective IPAC measure to prevent the spread of germs.¹ In general, hand hygiene refers to how to clean your hands.⁷ There are two ways to perform hand hygiene. ⁷ It is common knowledge that washing your hands at a sink with soap and warm running water removes germs, but when hands are not visibly soiled, hand hygiene can also be performed using alcohol-based hand rub (commonly referred to as ABHR or hand sanitizer), which also kills germs. ⁷

Hand hygiene also includes hand care.⁷ Having dry or chapped skin may make using ABHR painful. Hand moisturizer that is compatible with ABHR should be used to keep hands healthy. ⁷ Hand moisturizers that are petroleum-based can damage gloves (if worn).⁷ If a worker has a problem with the skin on their hands, such as frequent breaks, irritation, or rashes, they should speak with their healthcare provider.⁵

Homelessness service setting providers should promote frequent hand hygiene among workers and clients to reduce the spread of germs, provide ABHR, and provide workers with training and information on infection control, including hand hygiene.²

ALCOHOL-BASED HAND RUB (ABHR)

The preferred method for hand hygiene, when hands are not visibly soiled, is to clean them using ABHR because it takes less time and is less harsh on skin compared to using soap and water. ⁷ The minimum concentration of alcohol in ABHR should be 70% but can range between 70% to 90% alcohol. ⁷ This is because ABHR with concentrations higher than 90% are less effective in killing germs, and are hard on the skin. Germs that are frequent causes of gastrointestinal outbreaks are usually killed by alcohol concentrations ranging from 70% to 90%.⁷

ABHR is convenient and can be made accessible in areas where hand wash sinks are not available. For homelessness service settings where there may be a risk of product ingestion of wall-mounted ABHR, it is recommended that workers carry portable/personal ABHR if possible.⁸ Carrying portable/personal ABHR also increases the opportunities to perform hand hygiene. Supervised ABHR can also be offered to clients to perform hand hygiene at designated times (e.g., before meals) if there is a risk associated with wall-mounted ABHR.

HAND WASHING

When hands are visibly soiled (e.g., have dirt on them) or feel sticky, they should be cleaned with plain soap and warm running water.⁵ If running water is not available, moistened towelettes followed by ABHR can be used.⁷

Hands should be cleaned:

- Before preparing, handling, serving or eating food.⁵
- After personal body functions such as using the toilet or blowing one's nose.⁵
- After contact with body substances, mucous membranes of the eyes, nose or mouth, or non-intact skin.⁵
- Before putting on and taking off PPE.
- Before and after client contact.⁷
- Whenever there is a chance that hands may have been contaminated.

JEWELLERY/NAILS AND GERMS

Wrist jewellery and watches can act as a source for germs. If a watch or wrist jewellery is worn, it should be pushed up the arm to allow hands and wrists to be cleaned when performing hand hygiene.⁷

Rings and long nails can be difficult to clean, can pierce gloves, and harbour germs. Chipped nail polish or nail polish worn longer than 4 days can also harbour germs that may be difficult to remove by hand hygiene. It's helpful to keep nails clean and short and to remove rings if you need to provide hands-on care to a client.

1.3 USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE is equipment worn for protection against germs and other hazards.⁹ Types of PPE include gloves, gowns, masks and respirators, goggles, and face shields.⁹ The choice of what PPE to use is based on your risk assessment, how germs can be spread and/or the risk of chemical exposure.

Homelessness service setting providers should ensure PPE is available and easily accessible, and that workers are provided with necessary PPE training. In homelessness service settings, PPE is usually available in a central location (such as an office), set up at PPE stations dispersed throughout the site, or provided directly to workers.

Homelessness service setting workers are responsible for selecting and wearing appropriately sized PPE based on their risk assessment of exposure to germs.¹ The risk assessment will help determine which PPE to use based on which part of the body could be exposed to body substances, non-intact skin, mucous membranes of the eyes, nose or mouth.⁵ When PPE is used properly, it protects the worker, the client, and the environment.⁵ The different types of PPE will be discussed in the following sections.⁵

Points to keep in mind about PPE:

- Access PPE with clean hands to avoid contaminating the PPE with germs from your hands.
- PPE should be put on right before the activity that requires it and removed immediately after the activity.

- PPE should be removed and discarded when soiled or damaged.
- PPE should not be worn when it is not needed. Doing so might accidentally contaminate the environment (e.g., a worker wearing the same gloves for various tasks where they may become contaminated with germs along the way).
- Workers should be trained in the proper way to put on and take off PPE.

GLOVES

Gloves are the most commonly used PPE in homelessness service settings.⁵ Gloves may need to be worn for occupational health and safety purposes, such as protecting a worker's hands from chemical injury.⁵ This section of the document will only focus on the use of gloves to prevent the spread of germs, as opposed to their use for protection when using chemicals.⁵ The gloves referred to in this section are disposable and should be considered single-use only.

Disposable gloves should be used with the idea of "one pair for one task". They should never be cleaned or re-used.

Homelessness service setting workers should wear gloves when their hands may come into contact with the following: blood or bodily fluids; items and environmental surfaces that are grossly contaminated with body substances; the eyes, nose, mouth or non-intact skin of a client.⁵ Wearing gloves will help protect the worker's hands from coming into contact with germs.⁵

In general, when helping a client, workers do not need to wear gloves if touching. Not all tasks require workers to use gloves. In fact, improper use of gloves (e.g., wearing the same pair of gloves from room to room) has been linked to the spread of germs.¹

Examples of commonly performed low-risk activities in a shelter which do not generally require the use of gloves⁵:

- Signing in at shift change
- Using the phone or computer
- Social touch, such as shaking hands
- Pushing a wheelchair
- Delivering snacks or drinks
- Attending a meeting
- Delivering clean linen or making a clean bed

Workers should always perform a risk assessment to determine if their hands are at risk for becoming contaminated.⁵ It's also important to follow the correct steps for putting on and taking off gloves to prevent contaminating hands or the environment with germs.

GOWNS

A gown should be worn when a homelessness service setting worker's risk assessment suggests that an activity is likely to generate splashes or sprays of body substances that might contaminate their forearms and/or clothing.⁵ Gowns should have long sleeves and fit snug at the cuffs. It should also fit comfortably and offer full coverage of the body front, from neck to mid-thigh or below.⁵ Workers should follow the correct steps to put on and remove a gown.

Points to remember about gowns⁵:

- Always wear a gown with the opening at the back. This prevents contaminating the clothing beneath.
- Gowns should be tied or fastened at the neck and the waist to prevent the gown from becoming loose or falling forward and contaminating clothing beneath.
- Choose a gown that fits well so that it provides adequate coverage of forearms and clothing.

MASKS

Masks should be used to protect the mucous membranes of the nose and mouth when there is a possibility that an interaction may consist of splashes or sprays of blood, body fluids, secretions or excretions when within two metres of a coughing client⁵.

Points to remember about using masks⁵:

- Wear a mask that fits your face securely and covers your nose and mouth.
- Masks should be removed after the task for which it was used and thrown out immediately.
- Do not re-use masks.
- Masks should not be touched while being worn. Used masks are considered contaminated. Touching a contaminated mask can contaminate your hands.
- Do not hang masks around your neck or on top of your head.
- A mask should be changed if it becomes wet as wet masks do not work effectively.
- If clients are ever provided with masks, they need to be taught the appropriate use of masks and will need access to new masks.

EYE PROTECTION

Eye protection should be used in addition to a mask to protect the mucous membranes of the eyes when there is a possibility that an interaction may consist of splashes or sprays of blood, body fluids, secretions or excretions when within two metres of a coughing client.

Points to remember about using eye protection⁵:

- Clean your hands before removing eye protection. This is so that your hands are clean before touching your face.
- Remove eye protection immediately after the task for which it was used.

- Throw out disposable eye protection after use. Disposable eye protection should not be reprocessed as it will damage the eye protection.
- If reusable eye protection is worn, ensure it is clean and disinfected properly according to your site's policy before the next use.
- Prescription eyeglasses should not be worn in place of eye protection. Wearing prescription glasses does not provide enough protection and may not protect eyes from exposure to germs in splashes or sprays of body substances.
- Eye protection should not be touched while in use as this may contaminate your hands and the eye protection.
- Never put eye protection on top of your head when not in use. Used eye protection is considered contaminated.

COMPLETE PPE

Based on a risk assessment, there may be times when a homelessness service setting worker is required to put on and take off full PPE (gloves, gown, and facial protection). It is important for workers to follow the correct steps for putting on full PPE to make sure that their hands, forearms, clothing, eyes, nose and mouth are protected. It is also important that the correct steps are taken to take off PPE to avoid contaminating hands, clothing, eyes, nose and mouth and to prevent spreading germs to the environment, other workers and clients.

1.4 CONTROL OF THE ENVIRONMENT/ENVIRONMENTAL CLEANING

Control of the environment includes measures that are built into the physical and organizational structure of the setting that reduce the risk of infection to workers and clients.¹ Examples include:

- Encouraging distance between client sleeping arrangements to help reduce the spread of germs.¹
- Maintaining mattresses and furnishings in good repair.
- Cleaning equipment and the environment effectively.
- Having ABHR and sharps containers accessible.¹
- Having appropriate ventilation to help reduce exposure to infections that can spread through the air.¹

1.5 SUPPORTING GOOD IPAC PRACTICES (ADMINISTRATIVE CONTROLS)

Administrative controls are measures that are put into place to protect workers and clients from infections.¹ Examples include:

- Implementing IPAC policies and procedures.
- Providing IPAC education and training to workers, volunteers and clients.
- Having schedules for cleaning and disinfection.

2.0 ADDITIONAL PRECAUTIONS

The concept of additional precautions refers to IPAC interventions that need to be used in addition to Routine Practices in order to protect staff and clients, by interrupting the transmission of infectious agents that are suspected or identified. These precautions are based on the potential mode of transmission.¹

Some of the elements of Additional Precautions which may be utilized in a homelessness setting are as follows:

- Specialized Accommodation: clients with symptoms of illness may require isolation on site, referral to an offsite isolation centre, or referral to an acute care hospital
- PPE: The PPE used should be specific to the type of additional precautions that are in place
- Additional cleaning and disinfection measures.

In homelessness settings, there may be situations where additional precautions are required, especially if clients have symptoms of illness. If clients are ill, they should be assessed by a healthcare professional.

Clinical symptoms that may require additional precautions are as follows¹:

Symptoms	Precautions Needed	Recommended Action
Diarrhea, vomiting with abdominal pain	Wear gloves and gown if skin or clothing will come into contact with the client or their environment	Keep client in private area where possible, or refer to acute care hospital
Respiratory infection with acute onset (influenza, COVID-19, common cold)	Wear mask and eye protection for interaction with client, and gown/gloves if entering patient environment. Provide mask to client.	Keep client in private area where possible, or refer to acute care facility
Respiratory infection with risk factors for tuberculosis	Provide client with mask.	Keep client in private area where possible, and refer to acute care facility
New onset rash	Wear gloves and gown if skin or clothing will come into contact with the client or their environment	Keep client in private area and refer for medical evaluation

3.0 CLIENT HYGIENE

The spread of many diseases and conditions can be prevented through appropriate personal hygiene and by frequently washing parts of the body and hair with soap and clean running water.¹⁰ Good personal hygiene practices can prevent the spread of hygiene-related diseases such as athlete's foot, body lice, scabies, and skin related issues.^{10 11}

Homelessness service setting providers and workers should encourage clients to maintain good personal hygiene (this may need to be built into the client's individual case plan) and assist clients in obtaining items to maintain basic hygiene and grooming when feasible.²

If feasible, homelessness service setting providers and workers should offer each client toiletries and personal hygiene items (e.g., soap, shampoo, a toothbrush, toothpaste, hygiene pads/tampons and incontinence products).² If available, these supplies should be accessible upon admission.² If possible, toiletries and hygiene supplies should continue to be provided for the duration of the client's stay.² Storing personal hygiene supplies in a communal manner should be avoided. If hygiene supplies are kept in a shared space, then they should be labeled with the client's name. Personal hygiene items such as shaving razors should be discarded if found in communal shower rooms or washrooms. Personal hygiene supplies should be dedicated to the individual client and not shared, in order to decrease the spread of germs.

To help maintain client hygiene, homelessness service setting workers and providers should ensure that each washroom is stocked with an adequate supply of toilet paper, liquid soap for dispensers, and paper towels (if there is no hands-free hand dryer accessible).²

If feasible, help clients obtain basic clothing and footwear that is appropriate for the season.² Foot problems are common among individuals experiencing homelessness, but are often overlooked.¹² Improperly-fitted shoes can lead to damaged skin resulting in foot infections that can be difficult to heal.²

3.1 RESPIRATORY ETIQUETTE

Respiratory droplets can spread up to 2 metres, and germs in respiratory droplets can spread easily in settings where people are in close contact.¹³ Respiratory etiquette are personal practices which include covering your cough with your elbow, sleeve or a tissue, promptly disposing of used tissues, and performing hand hygiene to help prevent the spread of germs.¹ Homelessness service setting providers and workers should reinforce respiratory etiquette with clients and other workers to help prevent the spread of germs found in respiratory droplets (e.g., the flu).¹³

Respiratory etiquette practices include the following¹⁴:

- Encourage clients to practice proper hand hygiene.
- Advise clients to practice respiratory etiquette when coughing or sneezing:
- Turn head away from others.
- Cover their nose and mouth with tissues.
- Throw out tissues immediately after use into the garbage.

- Perform hand hygiene immediately after throwing out tissues.
- Encourage clients to maintain a spatial separation of at least 2 meters from other clients when they have respiratory symptoms and for ill clients to seek medical attention.

You can offer a client a mask while in common areas if they have respiratory symptoms and are able to tolerate wearing a mask. Facilities should ensure education is provided to clients regarding the appropriate use of masks. Masks can help contain germs in respiratory droplets that are spread to others when speaking, laughing, coughing or sneezing. However, if a mask is not used appropriately, it can become contaminated and spread germs to others and the environment. It is important that clients have access to new masks when needed.

3.2 SKIN CONDITIONS

Germs can enter the body through non-intact skin. If hands have not been properly cleaned through appropriate hand hygiene, and these hands come into contact with non-intact skin, this can allow germs to enter the body.

Non-intact skin can also act as an exit point for infectious germs to leave the body and contaminate the environment such as linens, or clothing.

Homelessness service setting workers should encourage clients who have skin infections or breaks in their skin to keep their wounds covered with a dressing (bandaging) and to be seen by a healthcare provider for assessment and treatment.

Parasitic insects (e.g., head, body and pubic lice, and scabies) and other insects such as bed bugs can cause skin infections when the bitten area is scratched hard enough to break the skin, allowing germs to enter.

Parasitic skin infestations like lice and scabies occur more often in individuals with poor hygiene and those who are experiencing homelessness.¹⁵ Below is information on common insects that can lead to secondary skin infections.

LICE

The most common symptoms of lice are itching and broken skin from scratching.¹⁵ Signs of infestation may be bites and red, raised areas of the skin.¹⁵

Lice is usually treated with topical sprays/creams and shampoos.¹⁵ For clients with head lice, areas where their heads have rested (e.g., pillows, chairs) also need treatment. For clients with lice, machine wash and dry clothing, linens, and other items that the client wore during the 2 days before lice treatment using hot water at 55°C (130°F) and the high heat drying cycle.¹⁶ For items that cannot be machine-washed, they can be placed in an airtight bag for 10 days to two weeks.¹⁷ Head lice in particular will usually die within 48 hours without a source of blood.¹⁷

SCABIES

Scabies is a contagious skin infestation caused by mites and is spread by close contact with a person with an infestation or infested bedding.¹⁵ Infestation is common among clients with poor hygiene and those in crowded living conditions and scabies can also be carried by pets.¹⁵ Itching from scabies is often very intense and clients may find it unbearable at night.¹⁵ Signs and symptoms include white skin ridges formed from the burrowing of the mite that can usually be seen between fingers, on the palms and inner sides of the wrists, red pustules, and crusted lesions.¹⁵

Scabies is usually treated with scabicides (e.g., permethrin, crotamiton).¹⁵ Laundering client clothing and personal belongings with hot water and detergents can help eliminate mites.^{15 18}

BED BUGS

Bed bugs are small biting insects that can multiply quickly and travel easily.¹⁹ Bed bugs come out at night to feed on people and sometimes domestic animals.²⁰ It is possible for anyone to have an infestation of bed bugs, regardless of income or housing.¹⁹

Adult bed bugs can be as long as 10 mm and have an oval, broad, flat body and a short, broad head and look like an apple seed. Adult bedbugs are brown, young bedbugs are shaped the same, but are smaller (1.5 mm long) and lighter in colour. They darken after feeding.²⁰

Not everyone has skin reactions to bed bugs, and their bites may not be noticed right away. Bedbugs prefer locations where they can hide easily and feed regularly, like sleeping areas. Their flattened bodies allow them to hide in extremely small locations like baseboards, under wallpaper, behind picture frames, in electrical outlets, inside box springs, in mattress pads, and in night tables.²⁰

Homelessness service settings should have a pest control policy and procedure that includes regularly scheduled inspections and treatment by a licensed pest control company, documentation of all pest sightings and/or evidence of infestations and a communication plan to inform clients and workers of treatment plans.² Additionally, mattresses and furniture should also be pest resistant.²

If a client indicates that they were staying somewhere with known bed bugs or if they have bed bug bites, the client's clothing and bag carrying their belongings should be immediately washed and dried if possible. Washing and drying at high temperatures kills bed bugs. If drying is the only option, workers can tumble dry the client's clothing for 30 minutes in a hot dryer.²¹ Bed bugs usually die at temperatures of 50°C.²² If the client refuses to have their clothes laundered, build laundering their clothes and belonging into their case plan as it may take clients some time to agree to this goal.²¹

Once bed bugs are found, a quick response is needed to prevent an infestation. Homelessness service setting workers should record and track information when clients say that they have been bitten by a bed bug. Noting the date, number of clients affected and which sleeping area/part of sleeping area was affected can be valuable to the pest control operators.²¹

To minimize bed bugs²¹:

- Check a small sample of bedding in the morning. Look for small brown flecks (which is actually blood excreted by bed bugs after feeding). Look for bed bugs inside pillowcases, around elastic area of fitted sheets, along the seams and folds of the mattress and where the bed touches the bed frame.
- Position beds 3 to 6 cm away from the walls and other fixed furniture and make sure that blankets and sheets are not touching the floor.
- Vacuum to remove bed bugs from their hiding spaces. Workers can use the stiff brush attachment and a back-and-forth scraping motion on the surface of the mattress, and a nozzle for the seams and crevices to remove bedbugs and their eggs. This can be done on mattresses, box springs, bed frames, baseboards, non-washable furniture cushions, any rugs and carpeting, baseboards, and the inside and underneath all drawers and furniture. The vacuum cleaner should be emptied immediately, and the contents sealed in a bag prior to disposing of it. After, the vacuum should be sealed in a plastic bag.²²
- Check for small tears in mattresses as this allows bed bugs to go deeper into the mattress. If a mattress is torn, immediately, apply a heavy-duty tape as a temporary solution and inform a supervisor.
- Inspect cracks and crevices in baseboards, walls and floors and inform a supervisor if any of these require filling.

4.0 FOOD SAFETY

Homelessness service settings may provide meals prepared in-house by workers/volunteers or have communal kitchens where clients are able to store and prepare food on their own. Some sites may also provide pre-made meals obtained through a distributor or catering company.

Regardless of how food is prepared or obtained, safe food handling practices should be encouraged to workers and clients to prevent cross-contamination and foodborne illness.

At a minimum, homelessness service setting providers should:

- Have procedures in place in relation to food preparation, handling, storage and transportation.
- Ensure that all food is prepared, handled, stored and transported in a hygienic manner that follows food preparation requirements prescribed by law and enforced by TPH.
- Ensure that donated food is safe, of good quality from an inspected source and is protected from contamination.²

Homelessness service setting providers are also encouraged to:

- Ensure workers who handle and prepare food, as well as their supervisors, have a valid Food Handler's certificate and clients and/or volunteers involved in food preparation should be supervised by a certified food handler.²
- Educate workers on the below food safety tips.

Homelessness service settings that prepare food on-site should be regularly inspected by TPH Healthy Environment's Food Safety department.² For more information about food safety and food premise inspections, contact Toronto Public Health at 416-338-7600.

4.1 FOOD SAFETY TIPS

FOOD PREPARATION

Food preparation should begin with clean cooking spaces and surfaces.²³ Hands should be cleaned properly and cooking equipment, surfaces and any food contact surfaces should be cleaned thoroughly.²³

To avoid the growth of harmful germs, meat should not be left out at room temperature for any length of time and should be discarded if left out for more than 2 hours.²⁴ If meat is being marinated, this should occur in the refrigerator.²³

CROSS-CONTAMINATION PREVENTION

Cross-contamination can make ready-to-eat food unsafe to eat and typically happens in three ways:²³

- Raw meat and/or its juices come into contact with cooked or ready-to-eat food.
- Dirty hands come into contact with cooked or ready-to-eat food.
- Dirty utensils come into contact with cooked or ready-to-eat food.

To prevent cross-contamination, workers should use a separate cutting board for raw meat.²³ Additionally, raw meat (and the juices from raw meat) should be kept away from cooked or ready-to-eat food.²³ Workers should properly clean their hands after handling raw meat and their juices.

INTERNAL FOOD TEMPERATURES

Harmful germs cannot be seen, smelled or tasted, which is why it is important that food is cooked to a safe internal cooking temperature to help kill the germs and avoid food poisoning. Checking the temperature of cooked meat, poultry, and seafood with a food thermometer is the only reliable way to make sure food has reached a safe internal cooking temperature. Safe internal cooking temperatures vary for different types of foods, so it is important to be aware of what internal temperature certain foods need to reach to kill germs (like bacteria) to become safe to eat.²⁵

REFRIGERATOR AND FREEZER TEMPERATURES

Do not overload a refrigerator and freezer, as cool air must circulate freely to keep food properly chilled.²⁶ Refrigerators should be run at 4°C or slightly colder to keep germs from multiplying. Freezers should be set at 18°C. Freeze fresh meat, poultry or fish immediately if it can't be used within a few days.²⁶

DEFROSTING FROZEN FOOD

Frozen food can be safely defrosted in a container in the refrigerator, microwave or under running cold water. When defrosting food in the refrigerator, place the food on a plate (or in a container) on the bottom shelf and allow 10 hours of defrosting time per kilogram of frozen food. When defrosting food in the microwave, be sure to cook the food immediately after defrosting. If food is left out at room temperature harmful germs (like salmonella) can grow on the outer surface of the food before the inside defrosts which can make it unsafe to eat.²³

REHEATING AND MICROWAVING FOOD

Reheat food like sauces, soups and gravy by bringing them to a rolling boil until they reach an internal temperature of 74°C (165°F). An accurate probe thermometer should be used for at least 15 seconds to check the internal temperature of cooked and reheated foods. Reheat different food items separately as they will likely take a different amount of time to properly heat up.²³

Microwaving sometimes leaves cold spots in food where bacteria may survive. To prevent cold spots, stir and rotate the food often. Cover the food container with a microwave safe lid or plastic wrap, leaving a small section uncovered so steam can escape, and don't let the wrap touch the food. Standing time is additional cooking that occurs after microwaving stops. Ensure that standing time as called for in a recipe or package directions is complete before eating the food. Use a probe thermometer to check that the food is cooked to the correct internal temperature.²³

HANDLING LEFTOVERS

Keep foods out of the danger zone, between 4°C (40°F) and 60°C (140°F) to prevent the growth of harmful germs. Additionally, throw away any cooked food left out at room temperature for more than 2 hours.²⁷

5.0 ENVIRONMENTAL GUIDELINES

The physical environment can harbour germs that can cause infections in workers and clients. Research conducted in healthcare settings, has shown that the environment can contain harmful germs that may be transferred to clients and equipment by the hands of healthcare providers.¹ Keeping a clean and safe environment is an essential aspect of IPAC and is important for the safety of clients, and workers.¹

5.1 CLEANING AND DISINFECTING

Cleaning is the physical removal of foreign material (e.g., dust, soil etc.) and organic material (e.g., body substances) off an environmental surface.²⁸ Cleaning does not kill germs, it physically removes them using water, detergents, and mechanical action (friction).²⁹ Detergents lift the oils and dirt off the surface, allowing them to be washed away with water.²⁹ The key to cleaning is the use of friction (e.g., scrubbing and rubbing) to remove germs and debris.²⁸ This needs to occur in order for a disinfectant to kill germs.

Disinfection is a process that should be completed after cleaning. It is the process of killing most germs on objects using chemicals or heat.¹³ Chemical disinfectants cannot work if there are body substances or dirt present, these must be removed first by cleaning.²⁹

It is important that disinfectants are used according to the correct contact time in order for it to do its job to kill germs. The term **contact time** means the amount of time that a disinfectant needs to be wet on a surface for it to be effective against the types of germs listed on its label.³⁰

Surface types are important to consider when determining frequency of cleaning and disinfecting. Some surfaces may require cleaning only and some both cleaning and disinfecting.

High-touch surfaces may include doorknobs, toys, cribs/cots, elevator buttons, light switches and computer keyboards that are touched frequently with hands throughout the day.⁵⁷ High-touch surfaces require frequent cleaning and disinfection at least daily, and more frequently where the risk of contamination is higher than usual (e.g., if there is increase in illness at the site).⁵⁷

Low-touch surfaces may include floors, walls and windowsills that are touched less frequently with hands throughout the day.⁵⁷ Low-touch surfaces require cleaning on a regular (but not necessarily daily) basis, and require immediate cleaning when visibly soiled.²⁸

Other surfaces such as carpeted floors are usually more heavily contaminated for prolonged periods than non-carpeted floors and can be a reservoir for germs (e.g., norovirus).²⁸ Carpets are not recommended in homelessness service settings, but if used, they should be vacuumed regularly, cleaned right away if a spill occurs, and shampooed/steam cleaned every 3-6 months.¹³ If a soiled carpet cannot be properly cleaned, it should be replaced as soon as possible.¹³ Other surfaces such as floor mats that are soiled and cannot be adequately cleaned and disinfected should be promptly removed and replaced.¹³

Cleaning and Disinfecting Principles

- Use PPE appropriately.
- Read and follow all manufacturer instructions for cleaning and disinfectant products.
- Cleaning is a critical step before disinfection.
- Clean and disinfect in progression from low-touch to high-touch surfaces, from cleaner areas to dirtier areas, and from top to bottom. This helps prevent contaminating the clean areas.
- Do not 'double-dip' cloths. Only put clean cloths into the cleaning or disinfectant solution.²⁹

CHOOSING A CLEANING PRODUCT

Cleaning products used in homelessness settings should:

- Be effective on the finishes, furnishings, surfaces and equipment used in the shelter.^{28 13}
- Be compatible with disinfectants used in the setting.¹³
- Have a drug identification number (DIN) from Health Canada (if it contains a disinfectant).²⁸
- Have a safety data sheet (SDS) and instructions for use available to workers who will be using it.

CHOOSING A DISINFECTANT

Facilities should consider using a ready-to-use/pre-mixed disinfectant, which is ideal for ease of use compared to mixing chemicals on site.¹³

Disinfectant products used in homelessness settings should:

- Have a drug identification number (DIN) from Health Canada.⁵⁷
- Be effective on the finishes, furnishings, surfaces and equipment used in the setting.³¹
- Be compatible with the cleaning products.¹³
- Be stable in concentrate or diluted form and have a pre-determined shelf-life.¹³
- Be active at room temperature and have a recommended short contact time.²⁸
- Not pose occupational health issues.
- Have an SDS and instructions for use available to workers who will be using it.

Providers should:	Providers are encouraged to:	Workers should:
Implement an environmental cleaning and disinfection program that should have:	Have procedures for enhanced cleaning and disinfecting during an outbreak. ¹³	Use cleaning and disinfecting products according to the manufacturers' recommendations. ^{28 32}
What needs to be cleaned and frequency of cleaning/disinfecting. ²	Provide training on proper use of cleaning products and disinfectants.	Know where cleaning and disinfectant products and supplies are located.
Who is responsible for the cleaning/disinfecting. ¹³	Have a policy and procedure for obtaining custodial services in emergency situations. ²	Lock away cleaning and disinfecting products when not in use/store them in a dedicated room or cabinet. ²⁸
Who is responsible for cleaning/disinfecting specific areas of the site.	Designate a dedicated room for cleaning supplies.	Follow policies and procedures.
Information (e.g., SDS, manufacturer instructions) on cleaning and disinfectant products are being used in the setting. ¹³	Post and monitor schedules for cleaning and disinfection (e.g., on washroom door).	Avoid cross-contamination and growth of germs by keeping equipment clean. ²⁸
Provide PPE.	Provide a cleaning caddy or cart for cleaning supplies (e.g., PPE, cleaning and disinfecting products, ABHR, garbage bags) to decrease the spread of germs while cleaning.	Ensure cleaning and disinfectant products are not expired before use.
Choose appropriate cleaning and disinfectant products (e.g., products that are compatible with each other and effective/appropriate for the setting).		Launder mop heads after daily use or when soiled and let them dry thoroughly before storage. ²⁸
		Label cleaning and disinfecting products. ²⁸
		Not carry equipment used to clean toilets from room to room. ²⁸
		Clean and disinfect high-touch surfaces at least daily. ²⁸

Use appropriate PPE based on the risk of exposure to germs and based on the SDS.

Not "top-up" cleaning or disinfectant solutions.

5.2 CLIENT PLACEMENT

Research has shown a clear relationship between the use of single rooms and reduced rates of infection.¹ The use of multi-bed rooms commonly used in many homelessness service settings can present an increased risk for the transmission of germs. It is helpful to have clear protocols in place regarding client placement in order to decrease the risk of transmission of germs to others.¹

Providers should:	Providers are encouraged to:	Workers should:
Attempt as much as possible to maintain 2 metres of facial separation between clients in sleeping areas to decrease the transmission of germs.	Prepare floor plans that show the spacing of the beds/cots/mats in designated sleeping areas. ² Keep designated sleeping areas physically separate from dining areas and other communal areas. ² Consider changing client sleeping arrangements in a way that increases the distance between client faces (e.g., staggered).	Let a supervisor know if a client is having respiratory symptoms to consider increasing bed spacing.

5.3 LINEN, MATTRESSES, AND SLEEPING MATS

Germs can spread, potentially survive and transfer onto individuals.³⁴ Cloth surfaces (such as curtains, mattresses, pillows and soft furnishing) have been shown to have higher concentrations of germs than non-porous surfaces. Stuffing and foam of sleeping equipment such as mattresses and sleeping mats cannot be cleaned properly if there are breaks in the fabric. An alternative to cloth surfaces should be used if feasible.²⁸

When items with cloth surfaces are used, they should have removable covers for cleaning and be replaced as soon as possible if damaged.

Providers should:

- Have a linen changing schedule.²
- Keep clean and soiled linens separate.²
- Provide clean bedding for each client.²
- Have a cleaning plan for cloth surfaces.²⁸
- Have a cleaning plan for mattresses/sleeping mats/cots.
- Have mattresses/sleeping mats that are seamless where possible (or have double-stitched seams) or be pest resistant.²
- Have a mattress, sleeping mat and pillow replacement plan.²
- Have an inspection schedule for bed bugs and common defects (e.g., stains, rips and tears).²
- Have quick-drying mattresses/sleeping mats with foam cores resistant to mould.²⁸

Workers should:

- Inform a supervisor of any damaged mattresses, sleeping mats, or pillows.²⁸
- Immediately remove or bag soiled linen with appropriate PPE .²⁸
- Keep mattresses clean.²⁸
- Educate clients about not sharing used linen with other clients to prevent the spread of germs.
- Inspect mattresses for pests when changing linens.
- Clean and disinfect client sleeping equipment (e.g., mattresses, mats, cots) between client use and as needed.

5.4 LAUNDRY

Bed sheets, linens and clothes have been shown to harbour germs that readily grow in the moist, warm environment next to an individual's body. Laundry policies and procedures should be in place and followed.

Points to remember when handling soiled linens²⁸:

- Bag or contain contaminated laundry immediately and do not sort or pre-rinse contaminated laundry in non-laundry facilities.
- Handle contaminated laundry with minimum agitation to avoid having germs go into the air which can land on surfaces, other clients and workers.
- Contain wet laundry before placing it in a laundry bag (e.g., wrap it in a dry sheet or towel).
- Linen bags should be tied securely and not be over-filled.
- Be mindful of sharps when handling linens.

Providers should:	Providers are encouraged to:	Workers should:
<p>Provide policies and procedures that address the collection, transport, handling, washing and drying of soiled linen which include protection of staff and hand hygiene.²⁸</p> <p>Establish a schedule for regular laundering of bedding, crib sheets and towels that accounts for regular use, soiling and contamination.²</p> <p>Provide laundering facilities onsite as a dedicated space or have a contract in place with a laundering service for bedding and linens.²⁸</p>	<p>In settings where clients are expected to launder their own items at laundry facilities on-site:²</p> <ul style="list-style-type: none"> • Provide instructions about the safe use of laundry facilities. • Launder client bedding and towels on the client’s behalf if the client is not willing or able to launder these items. • Offer laundry soap to clients. 	<p>Follow policies and procedures provided about the collection, transport, handling, washing and drying of soiled linen.²⁸</p> <p>Use laundry equipment according to the manufacturers’ instructions.²⁸</p> <p>Wear appropriate PPE.²⁸</p> <p>Do client laundry as a separate cycle from environmental cleaning items (e.g., cleaning cloths and mop heads).</p> <p>Be mindful of sharps when collecting soiled linens (e.g., handle linen and laundry from corners/edges so you can see what is in your hand).</p> <p>Provide clients with a means to store dirty laundry (e.g., laundry bag).</p> <p>Ensure that:²⁸</p> <ul style="list-style-type: none"> • If linen is washed at a high temperature (greater or equal to 71°C (160°F)), use a hot water detergent for a complete wash cycle (longer than 25 minutes). • If laundry is washed at a low temperature (less than 71°C (160°F)) use a detergent suitable for low temperature and for a complete wash cycle.

5.5 TOYS

While toys can be therapeutic, recreational, and educational, they often become contaminated with germs.³⁵ Toys can be a reservoir for potentially infectious germs that can be present in saliva, respiratory droplets, feces or other body substances and have been associated with clusters of illness.²⁸

Providers should:

Ensure that all toys and activity materials owned by the homelessness service setting are smooth, non-porous, do not retain water and are fully cleanable.²⁸

Ensure that toys and activity materials owned by the homelessness service setting are cleaned and disinfected according to a regular schedule which should take into consideration that:^{2 13}

- Infant toys should be cleaned and disinfected daily (or as needed).
- Toddler and pre-school toys should be cleaned as needed and disinfected weekly (or as need).
- Toys for older children should be cleaned and disinfected monthly (or as needed).

Have procedures for cleaning toys which includes:^{28 57}

- Frequency and methods of cleaning.
- Assigned role of responsibility for cleaning.
- Inspection for damage, cracked or broken parts.
- Options for disinfection (e.g., use of a commercial dishwasher (must reach 82°C), or an approved disinfectant).
- Thorough rinse following disinfection and air-drying prior to storage.

Workers should:

Encourage children to practice hand hygiene before and after playing with toys.¹³

Inspect toys for damage to avoid affecting the cleaning and disinfection process and throw away as necessary.¹³

Empty, clean and disinfect toy storage boxes/cupboards and inspect bins for pests on a scheduled basis.¹³

Clean high-touch play surfaces on a daily basis.¹³

Clean and disinfect shared electronic equipment that is touched frequently like video games and computers daily. If feasible, use computer keyboard covers which are easier to clean and disinfect.¹³ Disinfectant wipes may be used for items that cannot be soaked.³⁶

Launder plush/soft toys.

If a worker notices a toy that belongs to a client that cannot be cleaned (e.g., playdough), it should be dedicated to the individual client, and either be sent with the client or thrown away when they leave the homelessness service setting.²⁸

Points to remember when cleaning and disinfecting toys:

Toys must be cleaned, rinsed and dried before disinfection. This is to prevent the disinfectant from being watered down.

- Ensure that the disinfectant being used is safe and suitable for the intended purpose and that the manufacturer's directions for dilution and contact times are followed. Do not use phenolics as this can cause skin and respiratory issues particularly for children.
- Ideally hard toys should be cleaned and disinfected using the 3-compartment sink method or a dishwasher. The 1st sink is used for washing with detergent, the 2nd sink is used for cleaning with water, and the 3rd sink is used for disinfecting.
- The 2-compartment sink method is acceptable if washing and rinsing are done in the first sink. If no sinks are available, then the 3-bin method is acceptable.¹³

5.6 CLEANING UP BODY SUBSTANCES

Body substances (e.g., blood, body fluids) should be considered potentially infectious. Spills must be contained, and the area cleaned/disinfected immediately.^{37 28}

Providers should:	Workers should:
Have policies and procedures that include: ²⁸ <ul style="list-style-type: none">• Responsibility for cleaning in each area during all hours.• A timely response.• A method to contain/clean the spill.• Proper disposal of waste.• Documentation of the incident.• How to deal with an occupational exposure.²	Assemble materials to clean the body substance prior to putting on PPE. ²⁸
Provide PPE, equipment/supplies, waste and linen disposal.	Be mindful of splatters and restrict the area until it has been cleaned, disinfected and is dry. ²⁸
Provide training on how to clean up body substances.	Wipe up/absorb any blood or body fluid immediately using either disposable or paper towels prior to cleaning and disinfecting the area.
	If the spill occurred on a carpet, mop as much as possible with a paper towel and let a supervisor know so it can be wet/steamed cleaned.

6.0 CLUSTERS OF ILLNESS

A "cluster of illness" is when there is an increase in the number of people with a particular illness or similar symptoms. Illness clusters can happen in any type of setting including healthcare facilities, workplaces, homelessness service settings, or in the community. The approach to manage a cluster of illness depends on the type of infection, the group of people who are infected, and the setting.

If a homelessness service setting thinks that there is an increase in the number of clients with an illness, they can contact TPH to assist in determining if a cluster exists. TPH may provide education on IPAC practices and control measures that can be implemented to reduce the potential for further spread of the illness. It is very important to encourage ill clients to seek medical attention as soon as possible.

TPH conducts community surveillance and may notice an increase in a particular disease associated with a homelessness service setting. This can lead to TPH contacting the homelessness service setting to discuss the possibility of a cluster of illness.

Contact TPH for assistance in determining if a cluster of illness exists at 416-338-7600. It is helpful to have the following information:¹³

- The date and time of the first ill individual.
- The date and time of the most recent ill individual.
- The total number of clients and workers per floor.

- Total number of ill clients and workers per floor.
- The symptoms of illness (e.g., diarrhea, vomiting, fever).
- The things that have been done so far to help stop the spread of the illness.

Illness cluster control measures may include:¹³

- Reviewing hand hygiene practices with workers and clients.
- Increasing the frequency of cleaning and disinfecting of common areas, high-touch surfaces and toys.
- Adjusting the concentration or changing the disinfectant product.
- Suspending communal activities or recreational visits by outside groups.
- Reinforcing the appropriate use of wearing PPE.
- Ensuring change table areas are disinfected appropriately after each use.
- Encouraging spatial separation for client sleeping arrangements.
- Discouraging the sharing of personal use items.

7.0 OCCUPATIONAL HEALTH AND SAFETY

The Occupational Health and Safety Act (OHSA) provides a legal framework that sets out the rights and duties of all parties in the workplace and helps establish procedures for dealing with workplace hazards including exposure to infections.^{38 39}

A Joint Health and Safety Committee (JHSC) consists of least two people that represent the workers and the employer whose main role is to identify workplace health and safety problems and bring them to the attention of the employer. A JHSC is required if the workplace regularly employs 20 or more workers. Workplaces with more than five but less than 20 workers should select an individual to be the health and safety representative.³⁹

The employer has the greatest responsibility for health and safety in the workplace.³⁹ However, one of the main purposes of the OHSA is to help build a strong internal responsibility system (IRS). This means that everyone has a role in keeping the workplace safe and healthy.³⁹ Some general duties are listed below:

DUTIES OF THE EMPLOYER:^{40 59 62}

- Take every precaution reasonable to protect workers, which includes protection from the hazards of infection.
- Provide information, instruction and supervision to workers to protect their health and safety (e.g., identifying jobs that have a risk of exposure to infections and insuring workers are informed of the risk, protection measures, and post-exposure protocols).
- Provide PPE and make sure workers wear and use the right PPE.
- Create and regularly review safe work policies and procedures (e.g., IPAC policies/procedures).
- Make sure workers follow the law and workplace health and safety policies and procedures.
- Make sure supervisors know what is required to protect worker health and safety.

DUTIES OF SUPERVISORS:^{40 59 62}

- Educate workers on health and safety and risks (e.g., PPE training, IPAC training).
- Ensure workers on the use of PPE and ensure that PPE is available for workers.
- Inform workers of occupational health exposure reporting procedures.
- Review IPAC procedures and training plans with the joint health and safety committee or a representative.
- Respond to reported health and safety hazards.

DUTIES OF WORKERS^{40 59 62}:

- Attend required IPAC/PPE training and education.
- Follow regulations and safe work policies and procedures.
- Use PPE appropriately.
- Know and follow the appropriate post-exposure reporting procedures.
- Report hazards or infections acquired in the workplace.

7.1 WORKER IMMUNIZATION

Homelessness service setting providers should advise that workers consult a healthcare professional about updating their vaccinations, including COVID-19 vaccination, annual Influenza vaccination, and completing a TB skin test.² Homelessness service setting workers should be aware of their immunization status.

The Canadian Immunization Guide (2017) recommends that homelessness service setting workers receive all vaccines routinely recommended for adults. In addition, hepatitis B vaccine is recommended if the worker is at risk of exposure to blood or body fluids. A blood test to confirm if the worker is immune to hepatitis B should be done by a healthcare provider 1 to 6 months after completing the vaccine series.⁴¹

7.2 SHARPS SAFETY

Sharps are items such as needles, razor blades, scissors, knives and broken glass that can cut or puncture the skin. If sharps that are contaminated with harmful germs or blood penetrate the skin, they may carry the germs into the body where an infection can occur.⁴²

Homelessness service setting providers should provide education regarding the safe handling of all sharps, provide sharps containers and dispose of sharps properly.² Providers should also implement a sharps injury prevention program which includes providing education to workers on the risks associated with unsafe practices (e.g., recapping needles) and a process for dealing with occupational exposures.¹

Sharps containers should be puncture-resistant, leak-proof, and designed to easily place a sharp into the container with one hand. They must be tamper-proof (i.e., difficult to remove the contents of or have a guard to prevent entry) and those in public areas need to be secured to a surface to prevent unauthorized removal. Many homelessness services settings have partnerships in place with agencies for sharps container removal, but

sharps in approved containers can also be taken to a local pharmacy or the nearest Toronto Solid Waste Transfer Station.⁴²

Points about sharps:

- When picking up a sharp, bring a portable sharps container to the area where the sharp is found.
- Never recap sharps prior to disposal.
- Never dispose of sharps in the regular garbage.⁴²
- Discard needles immediately after use in an appropriate sharps disposal container.
- Replace sharps containers when $\frac{3}{4}$ full.
- Never use hands when cleaning up sharps such as broken glass; staff should use a broom and dustpan or forceps to pick up the material instead.⁴²
- Inform the supervisor immediately of a sharps-related injury.

7.3 EXPOSURE TO BODY SUBSTANCES

Homelessness service setting providers should have policies to deal with staff exposure to body substances such as blood.¹ A blood borne infection is an infection that can be transmitted through contact with infected blood and other potentially infectious body fluids. Hepatitis B, Hepatitis C and HIV are examples of blood borne infections.⁴³ Exposure to blood borne infections may occur in the following cases:⁴³

- Contact with blood or body fluids with a non-intact skin or with mucous membranes.
- Injuries that puncture the skin with needles or sharp objects contaminated with blood or body fluids.

Providers should provide workers with training and information about infectious diseases and procedures for dealing with occupational exposure to body substances and instructions for first-aid management for exposures.²

POST-EXPOSURE PROPHYLAXIS (PEP)

PEP is an emergency medical response given as soon as possible after a potential blood borne infection exposure to reduce the risk of transmission of a blood borne infection. It is available for HIV and hepatitis B.⁴³

Accidental exposure to potentially infected blood or other body fluids is a medical emergency and the following measures should be taken right away⁴³:

- First-aid care.
- Refer to a supervisor and report the accident as soon as possible (e.g., to document the situation and fill out necessary forms).
- Consult a healthcare provider right away for assessment and/or PEP (if applicable).

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APPENDIX 1: IPAC GUIDE TO COVID-19

Introduction

This guidance document is to be used in conjunction with IPAC COVID-19 Guidelines from Toronto Public Health, along with guidance documents from the Ministry of Health and the Chief Medical Officer of Health. The below guidance serves to add context and guidance to these documents and pathways in shelters and related Congregate Living Settings (CLS). Practice Health Check can assist facilities in the application of this guidance to their settings.

COVID-19 Background

COVID-19 is a disease caused by a coronavirus (SARS-CoV-2) that was first identified in December of 2019^{1,2}. First identified in the Wuhan province of China, this highly transmissible virus quickly spread across the world, causing a global epidemic.^{1,2}

The incubation period of the virus is approximately 2-10 days, but can take up to 14 days. A person with COVID-19 can be infectious approximately 2 days before the onset of their symptoms, up to 10 days after their symptoms start.^{3,4}

The most common symptoms of COVID-19 include fever, chills, body aches, and respiratory symptoms such as shortness of breath, coughing, runny nose and sore throat. People may also experience changes in smell or taste, gastrointestinal symptoms such as diarrhea, nausea, vomiting and abdominal pain. Persons who are over the age of 70 may experience atypical symptoms like increased falls, delirium, and worsening of chronic conditions.⁵

The disease is primarily spread via respiratory droplets; these exit the mouth and nose of people with an active COVID-19 infection, and enter through the mucous membranes of a susceptible person^{4,6}. It can also spread to a lesser extent through self-contamination after contact with contaminated surfaces. In small, closed and poorly ventilated spaces, there is also a risk of aerosol transmission, where the virus may stay in the air in aerosolized droplets for longer periods of time^{6,7}.

Testing

Tests for COVID-19 may differ according to the specimen collected for analysis, and according to the processes used to analyze that specimen for a result.

TYPES OF TESTS

As of August 2021, there are three different tests for COVID-19 available in the province of Ontario⁸. These have different uses and indications for use and are not used interchangeably. Each test should be used according to the Ministry of Health guidelines for testing, and according to the manufacturer's instructions for use.

- **NUCLEIC ACID AMPLIFICATION TESTS (NAAT) / POLYMERASE CHAIN REACTION (PCR) TESTS**

The most commonly used test for COVID-19 in Ontario is the PCR test. For this testing method, a specimen is usually taken from a person's nasopharynx, nose, or throat using a swab. Some tests may also use saliva. The swab is then sent to a laboratory, where the sample on the swab is analyzed to see if the genetic material of the virus is detectable. If the lab can detect the virus' genetic material, then the test may be called positive⁹.

PCR tests are used for diagnostic purposes when people have symptoms consistent with COVID-19 disease and/or to screen asymptomatic individuals who may have been exposed (pre-travel or during COVID-19 outbreaks/community surges), as they are more accurate in detecting or ruling out the presence of COVID-19.

- **ANTIGEN TESTS**

Antigen tests are another type of tests used for COVID-19. For this test, a specimen is usually taken from a person's nose using a swab. These tests do not always have to be sent to a lab, and in a lot of cases can be done at the point of care. Antigen tests detect specific proteins which are normally on the surface of the virus. Results are often obtained very quickly; most antigen tests currently used have a turnaround time of less than one hour^{9,10}.

These tests are not as sensitive to the presence of COVID-19 as the PCR test, meaning that they may miss some 'true positive' cases. As such, they should only be used for screening purposes, and not for diagnostic purposes.^{8,10} This means that rapid antigen testing should not be used for symptomatic people. Positive antigen tests should always be confirmed with a PCR-based test. Negative antigen tests should not be used to rule out infections in very high-risk exposures (e.g., close prolonged unprotected contact with a known positive case).

- **SEROLOGY (ANTIBODY) TESTS**

A third type of test used to detect COVID-19 is serology testing. For this test, a blood sample is taken from a person and sent to the laboratory. At the lab, tests are done to determine whether the person has developed antibodies to COVID-19; this usually means that the person has been exposed to COVID-19 or the vaccine at some point and their body's immune system has developed antibodies as a response⁸.

This test is not used for screening or diagnostic purposes. This is currently only done either for research purposes, or for very severe illnesses where PCR testing cannot be used, and serology testing is needed to help understand the patient's situation.

WHEN TO TEST

Facilities should follow the testing guidance from Toronto Public Health and from the Ministry of Health to determine when testing is indicated for a staff or client.⁸ PCR testing is highly recommended for symptomatic individuals in the highest risk settings. A general guide to testing is as follows:

- Staff/client has symptoms of COVID-19: PCR testing
- Staff/client has had a high-risk exposure: PCR testing
- Outbreak investigation: PCR testing

Rapid antigen testing may be recommended by Toronto Public Health or by the Ministry of Health for screening purposes among low-risk individuals (e.g., asymptomatic unvaccinated staff not known to have been exposed), or to expedite outbreak management.

Case Definition

A **confirmed case** of COVID-19 is a person with laboratory confirmation of a SARS-CoV-2 infection, documented by either a validated PCR or equivalent molecular test¹¹.

A **probable case** of COVID-19 is a person who (1) has symptoms of COVID-19 along with risk factors for COVID-19 (e.g. high risk exposures or travel to an affected area), with testing pending, or (2) has an inconclusive test result but has symptoms or risk factors (high-risk exposure, travel or outbreak).¹¹

Case and Contact Management

CASE MANAGEMENT

Management of confirmed and probable cases of COVID-19 should be done according to provincial guidelines as well as direction from the local public health unit¹². The local public health unit should be contacted to report any confirmed or probable cases in the facility.

In general, clients who are confirmed to have COVID-19 will be asked to isolate for their period of communicability (usually 10 days from lab test date or symptom onset). The specific duration of their isolation period will be determined by Toronto Public Health after a review of their clinical history (e.g., potential exposure, onset of symptoms, acquisition source).

Facility staff should use droplet contact precautions (gown, gloves, eye protection, and mask) for all close (<2meters) interactions with clients who have tested positive for COVID-19.

CONTACT MANAGEMENT

Management of staff or clients with potential exposure to COVID-19 (i.e. contacts) should be done according to provincial guidelines as well as direction from the local public health unit¹². Facilities may seek guidance from Public Health for individual cases as needed.

In general, contact management should include an assessment of the risk of exposure. A high-risk exposure involves unprotected close contact (i.e., prolonged interaction within two metres without the appropriate PPE) with a COVID-19 case during their period of communicability. If a staff or client is wearing a mask and eye protection, or has maintained the appropriate physical distancing, in most cases this would be considered a low-risk exposure and would not require testing or quarantine. High risk unvaccinated/unprotected exposures will, generally, be asked to self-isolate (aka quarantine) for 10 days from the last date of exposure. The vaccination status of the contact may also be taken into account; fully vaccinated people have a lower risk of acquiring COVID-19 and may be exempt from post-exposure quarantine in some situations, as directed by Public Health¹³.

COVID-19: Routine Practices & Additional Precautions

HAND HYGIENE

Hand hygiene is one of the most important measures in controlling the spread of infections. Due to the possibility of transmission via direct contact with clients as well as indirect contact with contaminated surfaces, it is important that both staff and clients practice meticulous and frequent hand hygiene¹⁴.

PERSONAL PROTECTIVE EQUIPMENT

Another important measure for the prevention of transmission of COVID-19 is the use of personal protective equipment. This document outlines the indication for the four types of PPE used as barriers to potential contact with COVID-19.

- **UNIVERSAL MASKING**

Due to the route of transmission of the COVID-19 virus (i.e. respiratory droplets), the use of face masks during all face-to-face interactions is a critical component of IPAC measures to prevent and control the spread of the virus¹⁵. Masks work both as source control, blocking the exit of respiratory droplets from the mask wearer, and as protection of portals of entry via the mouth and nose (during exposure to another individual).

Facilities should employ universal masking according to provincial and local public health unit mandates, and should use universal masking as a prevention measure during times of high community prevalence of respiratory illnesses.

- **EYE PROTECTION**

The mucous membranes of the eyes are potential portals of entry for the COVID-19 virus. As such, the use of eye protection (e.g., face shields, goggles) is important to prevent potential exposure. Facilities should ensure that eye protection is used for all face-to-face interactions with clients and colleagues^{15,16}. Most face shields and goggles can be cleaned and disinfected between uses and then put back on. Follow the manufacturer's instructions for cleaning.

- **GOWNS AND GLOVES**

Inappropriate use of gown and gloves is a frequent occurrence in situations where there is high anxiety and fear of infection. It is important to note that the use of gown and gloves outside of the recommended usage instances can actually lead to transmission and prolong outbreaks.

Facilities should ensure that gowns and gloves should only be used in the following instances¹⁷:

- For interactions with a client who is on isolation due to symptoms of COVID-19, a positive COVID-19 test, or high-risk exposure to COVID-19
- According to a risk assessment during which it is determined that there is a potential for contact with blood or bodily fluids.
- During a COVID-19 outbreak, when entering into client rooms in the designated outbreak area.

PHYSICAL DISTANCING

Physical distancing is an important routine practice for the prevention and control of COVID-19 transmission. This is based on the premise that the approximate travel distance of respiratory droplets is usually under 2 metres. Facilities should adhere to physical distancing guidelines from the Ministry of Health and the local public health unit^{14,16}.

Facilities should ensure that staff and clients adhere to physical distancing as much as possible, especially when the appropriate PPE (i.e., mask and eye protection) is not being worn.

Strategies should be used to facilitate physical distancing in common areas, such as floor markers and furniture arrangements. Common staff areas, such as lunchrooms, shared offices, locker rooms, should employ maximum capacity signage to ensure that staff are able to maintain the appropriate physical distance if/when masks are not being worn. Surveillance of adherence to distancing practices across the facility is important^{14,16}.

Client group and communal activities should be organized to allow for room capacities that allow for physical distancing¹⁶.

Environmental Cleaning

The SARS-CoV-2 virus, which causes COVID-19, is an enveloped virus. Enveloped viruses are highly susceptible to common disinfection methods. Most commonly used healthcare-grade disinfectants are effective against the COVID-19 virus, but it remains crucial to adhere to proper cleaning and disinfection manufacturer instructions for use, and to choose the correct products^{18,19}.

DISINFECTION

Disinfectants used in shelter settings must have a drug identification number (DIN) from Health Canada. A short contact time (<3 minutes) is recommended for ease of use. Disinfectants should be compatible with surfaces and equipment in the facility, and both the manufacturer's instructions for use (MIFU) and the safety data sheets (SDS) should be reviewed and adhered to¹⁸.

Surfaces should be cleaned of visible soiling prior to disinfection²⁰. Combination products (cleaner/disinfectants) should ideally be selected and used to facilitate the process. Disinfectants should be compatible with cleaning products being used by the facility, and products should not be mixed. The facility should have a single type of Health Canada designated cleaner/disinfectors for each of the various uses (floors, surfaces, washrooms, etc.) to facilitate training of the environmental cleaning staff (correct dilution, wet contact time, etc.) and correct/safe usage¹⁹.

NO-TOUCH DISINFECTION SYSTEMS

While facilities may opt to use methods of no-touch disinfection (e.g., fogging machines, electrostatic spray disinfection systems), it is important to note that these methods are designed as adjuncts to routine cleaning and disinfection. They do not replace routine cleaning and disinfection practices, and surfaces must be physically cleaned and disinfected before using these adjuncts²⁰.

No-touch disinfection methods also have health and safety risks to clients and staff who are present when the system is operating, and may cause damage to some surfaces after repeated exposure. It is important to adhere to the MIFU and to review the SDS for products used in no-touch disinfection processes. Disinfectants used in these systems must also have a DIN from Health Canada.

Emergency Situation Response

Shelter and Congregate Living Settings shall ensure that staff and volunteers have access to sufficient PPE to respond to emergency situations across the facility, particularly opioid overdoses. These emergency PPE kits should contain a gown, glove, mask, and face shield and meet the following criteria:

- Fit most individuals (i.e., up to size XL)

- Contain one set of PPE
- Labeled with the contents and marked “FOR EMERGENCY USE ONLY”
- Be placed in accessible locations which are known and obvious to staff throughout the facility in sealed containers to enable access within 2 minutes.
- Placed consistently across the building
- Available on every floor
- Available at each entrance
- Available in all harm reduction spaces
- Available at the security desk

The organization shall train workers and volunteers (anyone who works in the facility) on the existence, location, and use of these kits and expectations around resuscitation based on their role. A staff member from the organization must be responsible for the placement and maintenance of the kits on an ongoing basis with appropriate accountability to management (i.e., daily checks with sign-off).

Community safety teams working outside specific facilities are expected to carry appropriate PPE in order to respond to emergency medical situations.

Immunizations

In late 2020 and early 2021, Health Canada authorized the use of a number of vaccines for COVID-19. These vaccines have undergone rigorous scientific study, and have robust data and evidence of their effectiveness against COVID-19 vaccines²¹.

Vaccines have been shown to reduce the risk of acquisition and transmission of COVID-19, and are very effective in reducing the likelihood of severe symptoms, hospitalization and death. They have also been shown to reduce the occurrence and the severity of outbreaks in hospitals, congregate care settings and congregate living settings^{22,23}.

For more information on the vaccines that are currently approved for COVID-19 in Canada, please see the Ministry of Health [COVID-19 Vaccine-Relevant Information and Planning Resources](#).

Facilities should encourage staff and clients to be immunized against COVID-19 and should facilitate immunizations as much as possible.

Outbreak Preparedness

Facilities should ensure that plans are in place for management of outbreaks, including identification of the outbreak management team, methods of disseminating information to clients, staff and stakeholders, and strategies for case and contact management. Records should be readily available for Public Health on request, for example, staff/client screening, staff/client lists, group activity attendance lists and vaccination lists. Resources and guidelines for outbreak preparedness are available from Public Health Ontario, Toronto Public Health. For further guidance on managing an active outbreak, please refer to the PHCC Outbreak Management Guide.

Infection Prevention and Control Hubs

As a response to the COVID-19 pandemic, the Ontario government created local networks of IPAC expertise called IPAC Hubs²⁴. The hubs are led by hospitals and public health units, and include long term care homes, retirement homes, residential settings funded by the Ministry of Health, residential settings funded by the Ministry of Children, Community and Social Services, as well as municipal shelters and supportive housing.

This network allows facilities to access IPAC expertise, assistance, guidance, advice and direct support for IPAC practices. This includes IPAC education, coaching and mentoring, auditing and surveillance, outbreak management and support, developing connections to community of practice, policy and procedure development, and recommendations to improve and strengthen IPAC programs.

Facilities should ensure that they are engaged with their IPAC hub and can access IPAC support when needed.

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APPENDIX 2: COVID-19 OUTBREAK MANAGEMENT GUIDE

Introduction

This guidance document is to be used in conjunction with outbreak management guidelines from Toronto Public Health and the Chief Medical Officer of Health. The local Medical Officer of Health has ultimate authority with respect to outbreak management. The below guidance serves to add context and guidance to these documents and pathways, and allows for contextual application of outbreak management strategies to individual congregate living/shelter/shelter hotel settings. Practice Health Check can assist facilities in the application of this guidance to their settings.

Definitions

Public Health Investigation in Progress/Suspect Outbreak

In facilities that are not in confirmed outbreak, but where an individual or individuals (either staff or clients/residents) have been placed on self-isolation or quarantine due to confirmed or potential transmission of COVID-19, the term “public health investigation in progress” or “suspect outbreak” is used.

Confirmed Outbreak

An outbreak is currently defined as two or more epidemiologically-linked cases of COVID-19 in a client or staff that is determined to have been likely acquired within the facility. Please note that outbreak definitions may be updated according to evolving circumstances and emerging scientific evidence.

Period of Communicability

The time during which someone with COVID-19 is communicable, i.e., 2 days before through 10 days after the onset of symptoms.

High Risk Exposure

A [high-risk exposure](#) involves the absence of the appropriate personal protective equipment (i.e. mask and eye protection, or physical barrier separation) during close contact with a COVID-19 case during their period of communicability.

Low Risk Exposure

A [low-risk exposure](#) involves interaction with a COVID-19 case while wearing the appropriate PPE or while separated by a barrier, or only had a transient interaction (i.e. briefly in the same room or walking past).

Situation: Public Health Investigation in Progress

When a staff member or a client is diagnosed with COVID-19, this should lead to notification of the appropriate stakeholders and an investigation by the facility. This investigation seeks to determine the likely source of acquisition (within the facility or community acquired), and the risk of transmission within the facility.

Staff Case

COMMUNICATION

The facility will need to communicate with the staff member to ensure that the staff member is not continuing to work, to determine shifts worked prior to the symptom onset date or test date, and to obtain an accurate estimated return to work date based on the appropriate duration of self-isolation. The facility will need to notify the local Public Health Unit of a staff case.

CASE MANAGEMENT

Any staff member who has tested positive for COVID-19 will be required to self-isolate for a period of time determined by the local Public Health Unit (currently usually 10 days from symptom onset).

CASE ATTRIBUTION

The facility will need to do backward contact tracing to determine the likelihood that COVID-19 was acquired within the facility; the most likely scenario of facility acquisition is through contact with another known or probable case. In the absence of another known case, community acquisition is likely.

CONTACT TRACING

The facility will also need to identify all clients or staff who may have had high-risk exposures to the staff case during the period of communicability.

CONTACT MANAGEMENT

Staff and clients with exposure to COVID-19 should be managed according to the [Case and Contact Management Guidance document from the Ministry of Health](#). High-risk contacts (i.e. close unprotected contacts) should be asked to quarantine at home for 10 days post-exposure, with testing recommended according to [the Provincial Testing Guidance](#) document from the Ministry of Health. Note that rapid antigen testing should not be used to assess acquisition of COVID-19 after a high-risk exposure. PCR testing is indicated in this scenario.

Quarantine is not required for low-risk contacts. Isolation and testing are not indicated unless symptoms occur.

ADMISSIONS

The identification of a single community-acquired staff case should not result in halted admissions to the facility. Due to the current routine practice of universal masking in shelter settings, there should be considerable source control with staff cases, and high-risk client exposures are unlikely.

Facilities should have plans in place to supplement staffing for normal operations in the event that there are multiple staff exposures in a department or group of staff critical for operations.

Client Case

COMMUNICATION

The facility will need to communicate with the client to determine the appropriate duration of self-isolation. The facility will need to notify the local Public Health Unit of a staff case.

CASE MANAGEMENT

Any client who has tested positive for COVID-19 will be required to self-isolate for a period of time determined by the local Public Health Unit (usually 10 days from symptom onset). [Public Health Ontario](#) recommendations are that off-site locations be used to assist with physical distancing and self-isolation for identified cases, whenever feasible/possible.

CASE ATTRIBUTION

The facility will need to do backward contact tracing to determine the likelihood that COVID-19 was acquired within the facility; the most likely scenario of facility acquisition is through contact with another known or probable case. In the absence of another known case, community acquisition is likely.

CONTACT TRACING

The facility will also need to identify all clients or staff who may have been exposed to the client case during the period of communicability (i.e., 2 days before through 10 days after the onset of symptoms).

CONTACT MANAGEMENT

Staff and clients with exposure to COVID-19 should be managed according to the [Case and Contact Management Guidance document from the Ministry of Health](#). High-risk staff contacts should be asked to quarantine at home for 10 days post-exposure, with testing recommended according to the [Provincial Testing Guidance](#) document from the Ministry of Health. Note that rapid antigen testing should not be used to assess acquisition of COVID-19 after a high-risk exposure; PCR testing is indicated in this scenario.

High risk client contacts should be asked to quarantine and placed on droplet contact precautions if quarantine occurs within the facility. As with case management, off-site locations can and should be used to assist with physical distancing for high-risk contacts. [Public Health Ontario provides guidance for cohorting exposures](#); it is

our recommendation that all high-risk exposures, whether symptomatic or asymptomatic, be treated with the same level of additional precautions. Common spaces and communal activities should be halted during investigations and outbreaks.

ADMISSIONS

Most facilities should be able to continue to admit clients through the Public Health Investigation in Progress.

The identification of a single community-acquired client case may result in isolation of identified contacts which may limit admissions to part of the facility. The facility should work with Toronto Public Health to allow continued admissions. Risk mitigation strategies should also be considered, such as cohorting exposed clients and staff to designated areas within the facility, or transferring high-risk exposures to off-site recovery or quarantine centres.

Situation: Confirmed Outbreak

All Shelter Facilities

This section contains guidance that may be applied to all shelter types. Guidance for specific shelter types follow in sections below.

COMMUNICATION

The decision to confirm the outbreak will be made by Toronto Public Health, who will also review the outbreak control and containment measures required to be put in place by the facility as per [Public Health Ontario guidance for management of COVID-19 outbreaks](#).

Facility staff and clients should be notified when an outbreak is declared. Facilities should have a plan for this communication in the event of an outbreak.

OUTBREAK MANAGEMENT TEAM

Facilities should designate an outbreak management team (OMT) who can oversee the response and implementation of outbreak control and containment measures. This team should work with Toronto Public Health to identify the outbreak area for swift initiation of containment and control measures. The membership of the OMT is outlined in guidance documents by [Public Health Ontario](#).

ADDITIONAL PRECAUTIONS

All clients within the outbreak area should be placed on droplet contact precautions. Staff entering client rooms should wear their mask and face shield along with gown and gloves. Gowns and gloves should ONLY be worn when providing hands on/clinical care. Gowns and gloves should be changed after each client interaction, should not be worn in common areas (hallways, offices, elevators, etc.). Gowns and gloves should be discarded immediately upon exit of the client's room.

CASE MANAGEMENT

Any client who has tested positive for COVID-19 will be required to self-isolate for a period of time determined by the local Public Health Unit. [Public Health Ontario](#) recommendations are that off-site locations be used to assist with physical distancing and self-isolation for identified cases.

CONTACT TRACING

In an outbreak situation, facility acquisition is assumed for most cases identified in the duration of the outbreak. The facility will need to do backward contact tracing for each case to assist in determining the scope of the outbreak.

The facility will also need to identify all clients or staff who may have had high risk exposures to each identified & linelisted case, in order to assess the potential spread of the outbreak.

SURVEILLANCE TESTING

Surveillance testing may be offered to staff and clients located in identified outbreak areas in the facility. The initiation and intervals of testing will be determined by Toronto Public Health according to [Ministry of Health Testing Guidance](#) documents.

VACCINATIONS

While vaccines are not currently used for post-exposure prophylaxis in a community setting, residents with potential or known COVID-19 exposures in congregate living settings may be vaccinated at any time if they are asymptomatic (see [CDC for further information](#)). Practice Health Check recommends that vaccination of all staff and clients should be made a priority in the event of a confirmed outbreak. Facilities should coordinate with either Public Health or their acute care partners to arrange immunization clinics for staff and clients as soon as possible after an outbreak is declared.

COMMON SPACES & COMMUNAL ACTIVITIES

Common spaces should be closed, and communal activities should be halted. Facilities should have a plan to allow for harm reduction activities while mitigating the risk of transmission.

Meals should be delivered to clients within the outbreak area; communal dining should be halted.

CLEANING & ENVIRONMENTAL SERVICES

Facilities should employ an increased frequency of cleaning and disinfection practices for common areas, shared surfaces and high touch areas. Common areas should be disinfected at least twice a shift, shared surfaces should be disinfected between uses, and high touch areas should be disinfected once an hour.

While facilities may opt to use methods of no-touch disinfection (e.g., fogging machines, electrostatic spray disinfection systems), it is important to note that these methods are designed as supplements to routine

cleaning and disinfection. They do not replace routine cleaning and disinfection practices, and surfaces must be physically cleaned and disinfected before using these adjuncts.

No-touch disinfection methods also have health and safety risks to clients and staff who are present when the system is operating, and may cause damage to some surfaces after repeated exposure. It is important to adhere to the manufacturer's instructions for use and to review safety data sheets for products used in no-touch disinfection processes.

ESSENTIAL VISITORS/SERVICE PROVIDERS

Essential services, such as harm reduction visits and medical/nursing services, should continue during an outbreak. Facilities should engage with external service providers to ensure that continuity of care is in place. As much as possible, care providers should tend to clients in non-outbreak areas first, and tend to clients in outbreak area afterwards.

Hotel Shelters

Hotel shelters have an inherent advantage in outbreak containment and control, due to single occupancy accommodations with few shared spaces and services. The following outbreak control and containment measures are specific to these settings, and should be used along with the above guidance for all shelter settings.

PREPAREDNESS

Facilities should consider having a small area of the building (i.e., 3 to 4 rooms on one floor) kept empty and designated as an outbreak management area at all times, to facilitate ongoing admissions in the early stages of an outbreak.

OUTBREAK AREA

The outbreak investigation should include determining the locations of the cases and of potential high-risk contacts. If the cases and contacts are linked geographically within the facility (e.g., one or two floors), the outbreak area should be restricted to that geographical area.

CONTACT MANAGEMENT

Quarantine should be initiated for high-risk contacts during an outbreak. Off-site facilities may be used to facilitate quarantine and social distancing for high-risk contacts, when feasible/possible.

If off-site facilities are not an option, facilities may create a designated area for quarantine of high-risk contacts.

If a designated area cannot be created, high-risk contacts may isolate in their own room. Additional staffing may be required in order to limit mobility and ensure adherence to guidelines.

CLIENT COHORTING

Facilities should employ cohorting as a containment measure for outbreaks and as part of their contact management strategy, as per [Public Health Ontario guidelines](#) and [City of Toronto direction](#). Clients with high-risk exposures to COVID-19 should be relocated to one geographical area within the facility. Identification of this area should be done ahead of time as part of outbreak preparedness (PHC can assist shelter management with this task).

STAFF COHORTING

Staff members should be assigned to work with only one cohort of residents over the course of the outbreak; staff assigned to the outbreak area/cohort should not be assigned to other clients within the facility, and as much as possible should not work at other facilities. If staff are required to work throughout the facility, they should move from the non-outbreak areas (low risk) to the outbreak areas (higher risk), to avoid the possibility

of spread from the outbreak area to other parts of the facility. If possible, vaccinated staff should be assigned to the outbreak areas as an added control and containment measure.

ADMISSIONS & TRANSFERS

Admissions should only be restricted for the outbreak area. Other floors with no identified cases or contacts can continue to admit clients. Clients should not be transferred from the outbreak areas to other floors.

Closed Dormitory/Ward Room Shelters

OUTBREAK AREA

If cases and contacts are linked geographically, the outbreak area should be limited to that geographical area. The outbreak area should be expanded as risk for transmission continues to be evaluated.

CONTACT MANAGEMENT

Quarantine should be initiated for high-risk contacts during an outbreak. Due to physical layout and shared accommodation at closed dorm facilities, off-site facilities should be used as much as possible to facilitate quarantine and social distancing for high-risk contacts.

If off-site quarantine is not an option, quarantine should be initiated in client rooms, or relocated to the outbreak area. Designated facilities (e.g., bathrooms, showers, dining) should be assigned for all high-risk contacts to limit mobility.

CLIENT COHORTING

High risk contacts should be co-located in the same area and/or relocated to the outbreak area.

STAFF COHORTING

Staff members should be assigned to work with only one cohort of residents over the course of the outbreak; staff assigned to the outbreak area and cohort should not be assigned to other clients within the facility. If staff are required to work throughout the facility, they should move from the non-outbreak areas (low risk) to the outbreak areas (higher risk), to avoid the possibility of spread from the outbreak area to other parts of the facility.

If the outbreak is facility wide with concerns for exposure in multiple areas, staff from this facility should not work at other facilities for the duration of the outbreak.

ADMISSIONS & TRANSFERS

If the outbreak is among staff, admissions and transfers should continue uninterrupted to the facility, unless there is considerable evidence of breaches of IPAC practices by affected staff. In these cases, admissions may continue but it would be preferable to operate with lower occupancy due to staffing level concerns and potential transmission.

In general, if the outbreak is among clients, admissions and transfers should be halted for the outbreak area, but can continue for the rest of the facility. If transmission is widespread, then admissions should be halted for the entire facility.

Open Dormitory Shelters

The physical layout and accommodation arrangement of open dormitory shelter make controlling transmission a challenge in these settings. The priority and focus of outbreak management should be containment, and control measures should aim to reduce the risk of transmission out of the outbreak area and/or the facility. The following outbreak control and containment measures are specific to these settings, and should be used along with the above guidance for all shelter settings.

OUTBREAK AREA

Due to the limitations of physical distancing in open dorm settings, the entire dorm area where client cases are identified will often be considered the outbreak area.

CONTACT MANAGEMENT

Quarantine should be initiated for high-risk contacts during an outbreak. Due to the limitations of physical distancing, and the absence of single-room or limited shared accommodation, off-site facilities should be used as much as possible to facilitate quarantine and social distancing for high-risk contacts.

CLIENT COHORTING

It may be challenging to employ cohorting within open dorm facilities. The outbreak area should be considered one cohort, and high-risk exposures should remain within the outbreak area if unable to be transferred to an off-site recovery centre.

STAFF COHORTING

Staff members should be assigned to work with only one cohort of residents over the course of the outbreak; staff assigned to the outbreak area and cohort should not be assigned to other clients within the facility. If staff are required to work throughout the facility, they should move from the non-outbreak areas (low risk) to the outbreak areas (higher risk), to avoid the possibility of spread from the outbreak area to other parts of the facility. If possible, staff who are fully vaccinated should be assigned to the outbreak area as an additional control and containment measure.

If the outbreak is facility-wide with concerns for exposure in multiple areas, staff from this facility should not work at other facilities for the duration of the outbreak.

ADMISSIONS & TRANSFERS

Admissions and transfers should be halted for the outbreak floor or area. If the facility is unable to reduce the mobility of clients within the facility, admissions to and transfers across the facility should be halted for the duration for the outbreak.