CORONAVIRUS DISEASE 2019 (COVID-19):

INFECTION PREVENTION & CONTROL GUIDELINES FOR LONG-TERM CARE SETTINGS

NSHA INFECTION PREVENTION AND CONTROL
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Infection Prevention & Control Guidelines for Long-Term Care Settings

Respiratory infection outbreaks occur in long-term care (LTC) facilities (LTCF) throughout the year, but are more common during the winter months. The novel coronavirus, SARS-CoV-2, which is the cause of coronavirus disease 2019 (COVID-2019), may be introduced into a LTCF in Nova Scotia.

The residents in LTC settings are likely to be older, frailer, and have chronic conditions that weaken their immune systems or impair their ability to clear secretions from their lungs and airways. Residents of any group facility are also at risk because respiratory pathogens are more easily transmitted in an institutional environment.

In addition to the infection prevention and control (IPAC) guidance provided in this document, LTCF will also follow the most recent direction outlined in *COVID-19 Management in Long Term Care Facilities – Directive Under the Authority of the Medical Officer of Health*.*

It is anticipated that this guidance may evolve over time as new information becomes available.

General Guidance for LTC Settings

- LTCFs should follow the established visitor restrictions in place.
- LTCFs will ensure that an employee health policy or directive is in place to send employees home if symptoms develop while at work. Follow guidance from the Office of the Chief Medical Officer of Health.
- Staff, other caregivers, and volunteers with symptoms of an acute respiratory infection must not come to work and must report their symptoms to the LTCF manager or designate.
- Staff who develop symptoms of an acute respiratory infection at work must immediately self-isolate and report their symptoms to the LTCF manager or designate.
- Staff who have an exposure to COVID-19 must report that to the LTCF manager or designate for guidance on the need for work restrictions.
- Staff who test positive for COVID-19 must follow facility policy and direction of Public Health (PH).
- Testing for COVID-19 will follow direction of the Medical Officer of Health.
- LTC staff will follow Routine Practices, as well as Droplet and Contact Precautions, when within 2 metres of all residents with or under investigation for COVID-19, or their environment.
- Education and training sessions for managing acute respiratory illness including routine practices, hand hygiene, additional precautions, and proper use of personal protective equipment should be conducted regularly and as required, tracked, monitored, and recorded.
- All staff must work proactively to identify suspect or confirmed cases of COVID-19 in staff, residents, and any essential visitors, with a low threshold for testing (e.g. even mild symptoms).
- All staff will be provided with education to encourage participation in PPE conservation strategies.

Screening and Triage

Access Points

LTCFs should minimize access points and ensure that:

- Screening of all staff, residents, essential volunteers or visitors, contractors, and other outside care providers is conducted at all access points, prior to entry, for symptoms or known exposure to COVID-19.
- Screeners are protected with transparent barriers, which prevent droplet transmission to staff, and allow for communication between the screener and residents or other persons who present at screening
    - If a transparent barrier is not in place, screeners should be provided with appropriate PPE (e.g., gloves, gown, mask, and face or eye protection).
- All staff and any essential visitors are required to put on a mask at entry to reduce the risk of transmitting COVID-19 infection from staff or visitors to residents (which may occur even when symptoms of illness are not recognized).
- Masks, tissues, alcohol-based hand rub (ABHR) and a no-touch waste receptacle are available for staff, resident, and essential volunteer or visitor use at each entrance.
    - Consideration should be given to the security of supplies of PPE to prevent pilfering, but this should in no way inhibit or prevent necessary access to PPE.
- Signage (multilingual as required) is posted at access points instructing staff and essential volunteers and visitors:
    - NOT to enter if they have any signs or symptoms of illness,
    - Signs or symptoms may include: fever (or signs of a fever), new or worsening cough, sore throat, runny nose and/or headache, etc.
    - NOT to enter if they have been instructed to self-isolate or self-quarantine, and
    - To practice hand hygiene and put on a procedure mask on entry.
- All staff and visitors should be logged at entry and exit.
- Food and essential items should be delivered through a single access point. Every effort should be made to avoid unnecessary entry into the LTCF, and if entry is required, delivery personnel are screened as per other visitors.

Staff Screening & Management

- Staff screening must include a documented self-assessment for exposures, symptoms of COVID-19 and a temperature check at least once daily, twice daily if operationally feasible, and according to institution's policy including at the beginning of each shift and if they become symptomatic in the workplace. Follow *COVID-19 Management in Long Term Care Facilities –Directive Under the Authority of the Medical Officer of Health*.*
- Staff should maintain a minimum of 2 metres physical separation between each other throughout their shifts, especially during any breaks or lunch when they are not masked.
- If staff develop symptoms of COVID-19 at work, they should; immediately perform hand hygiene, ensure that they do not remove their mask, inform their supervisor, avoid further resident contact, and leave as soon as it is safe to do so.
- Staff with any symptoms (including mild respiratory symptoms) should be tested for COVID-19, excluded from work, and follow local Public Health and LTCF's organization guidance with regard to testing and further management

Resident Screening

- All new admissions and re-admissions to a LTCF should be screened for symptoms and potential exposure to COVID-19 and medical history taken to determine if resident has been tested, suspected, or diagnosed with COVID-19. Test resident for COVID-19 and place on Droplet & Contact Precautions for 14 days on admission, as per COVID-19 Management in LTCF Directive*.
    - These residents should be met by a staff member who is wearing PPE for Droplet and Contact precautions (e.g. gloves, gown, mask, and face or eye protection) and immediately escorted to a single room or a space where at least 2 metres between residents can be ensured.
- Those returning from essential medical appointments must be screened for symptoms and possible exposure to COVID-19.
    - Signs or symptoms include: fever (temperature of 37.8°C or greater or signs of fever), cough (new or worsening), sore throat, runny nose, headache, any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise or headache.
    - *NOTE: Symptoms in elderly residents may be subtle or atypical, and screening staff should be sensitive to detection of changes from resident baseline*
- Residents in NSHA facilities will be assessed at least twice a day for fever, new or worsening cough, sore throat, runny nose, and/or headache, and change in health that could reflect a respiratory infection. This assessment must be documented using the approved organizational form on the *COVID-19 ILI SYMPTOM MONITORING FOR INPATIENTS* form and placed on each resident's chart. Follow reporting directive* of Chief Medical Officer of Health and submit information to PH, as applicable.
    - Note: Symptoms in elderly residents may be subtle or atypical, and screening staff should be sensitive to detection of changes from resident baseline. The goal of active screening is to have a low threshold for detection of COVID-19 cases. Testing may be appropriate in some circumstances based on clinical knowledge and judgment, taking into consideration the resident's baseline health status.
- Staff should initiate and maintain a line listing of residents with suspected or confirmed COVID-19.
- In the context of the COVID-19 pandemic, a single laboratory-confirmed case of COVID-19 in a resident (or staff member) in a LTCF is an outbreak.
- Residents with suspected (testing pending) or confirmed COVID-19 infection will be cared for using the guidance below *Infection Prevention & Control Guidance for Caring for a Resident with Suspected or Confirmed COVID-19.*

Visitors

- LTCF must follow the PH and NSHA direction regarding visitor restrictions. LTCF are now closed to visitors except those deemed essential support services for the residents or for compassionate reasons.
- Guidance should be developed for essential visitors (e.g. compassionate reasons)
- Any essential visitor must be screened for signs and symptoms as described above; including any recent travel outside of Nova Scotia or known contact with a suspected or confirmed case of COVID -19. Consult PH for further advice regarding those on self-isolation.

- Visitor movement within the LTCF should be limited to visiting the resident directly and exiting the LTCF directly after their visit.
- Ensure that consideration is given to the potential impact visitor restrictions may have on resident physical, social, and emotional well-being. Consider use of one-on-one programs, and use of technology to allow resident contact with family or friends
- All visitors should:
    - Be required to put on a procedure mask at entry to the LTCF, to reduce the risk of transmitting COVID-19 infection to residents or LTCF staff, which may occur even when no symptoms of illness are recognized.
    - Be instructed by staff on the importance of hand hygiene with ABHR, and when and how to perform hand hygiene (e.g.: on entering and exiting the building, the resident room, and after touching any surfaces in the resident environment or the resident).
    - Be instructed on how to put on and remove any required PPE when visiting or caring for residents on precautions. If the visitor is unable to adhere to appropriate precautions, the visitor must be excluded from visiting.

Infection Prevention & Control Guidance for Caring for a Resident with Suspected or Confirmed COVID-19

Staff at LTCF will, in addition to Routine Practices, implement Contact & Droplet Precautions and use the correct personal protective equipment when entering a resident's space/room.

Routine Practices

Within LTCFs, Routine Practices should be consistently used with all residents.

The key to implementing Routine Practices is for health care workers in LTC settings to conduct a *Point of Care Risk Assessment* (PCRA) with each resident interaction. The PCRA will assess risk of transmission of microorganisms and assist staff to choose interventions or infection prevention and control measures to use. This includes assisting the staff member to select the appropriate PPE (See Appendix A).

Droplet & Contact Precautions

For cases of suspected or confirmed COVID-19, Additional Precautions (Droplet and Contact) will be implemented.

Airborne Precautions

Aerosol-Generating Medical Procedures (AGMPs)

- An AGMP is any procedure conducted on a resident that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs are rarely performed in LTCFs, though potential examples in this setting may include open suctioning in residents with a tracheostomy, or use of non-invasive positive pressure ventilation (CPAP) machines. Avoid use of nebulizer and use alternatives such as meter-dosed inhaler with spacer.

- An AGMP on a resident suspected or confirmed to have COVID-19 requires airborne precautions, including use of a fit-tested, seal-checked N95 respirator.
- AGMP is only to be performed if:
    - It is medically necessary and performed by the most experienced person
    - The minimum number of persons required to safely perform the procedure are present
    - All persons in the room are wearing a fit-tested, seal-checked N95 respirator, gloves, gown, and face or eye protection
    - The door of the room is closed
    - Entry into the room of a patient on CPAP is minimized
- *NSHA 2019 Novel Coronavirus Disease (COVID-19): Aerosol Generating Medical Procedures in Healthcare Settings* is available which provides recommendations and a list of activities considered to be AGMPs.

Accommodation

- Cohort staff to work with symptomatic or asymptomatic residents and restrict movement of staff between symptomatic and asymptomatic residents as much as possible.
- A resident with suspect or confirmed COVID-19 infection, or who is a high-risk contact of a confirmed COVID-19 positive person, should be cared for in a single room if feasible, with a dedicated toilet and sink designated for their use.
    - If this is not possible, cohort symptomatic residents whenever possible, and maintain a separation of 2 metres between the bed space of the affected resident and all roommates, with privacy curtains drawn. The resident should be restricted to their room or bed space.
- A sign should be visible on resident's door/bed space to indicate need for Droplet and Contact Precautions.
- Posters illustrating the correct method for putting on and removing PPE should be displayed inside and outside of each COVID-19 resident's room or bed space for easy visual cues for care providers.

Hand Hygiene

- Staff should perform hand hygiene frequently according to the *Four Moments of Hand Hygiene* using plain soap and water or an ABHR (70-90%). Soap and water should be used when hands are visibly soiled.
- Residents should be taught how and provided with opportunities to perform proper hand hygiene.
- Residents should have ABHRs made available to them and be assisted with hand hygiene by staff as needed. Staff may need to wash the resident's hands for them.

Personal Protective Equipment

- Appropriate PPE for **Droplet and Contact Precautions** should be available outside the resident's room for use by staff and essential visitors. This includes;
    - Gloves,
    - Long-sleeved cuffed gown (cover front of body from neck to mid-thigh),
    - Procedure/surgical mask (already worn due to mask during all off shift),
    - Face/eye protection (i.e. face shield, mask with attached visor, non-vented safety glasses, or goggles)
- N95 respirators are only necessary when conducting an AGMP.

- **LTCFs will implement universal or continuous masking practices for all staff who have contact with residents.**
    - All staff who have direct (face-to face) or indirect contact with residents will wear a procedure/surgical mask at all times.
    - Masks will be worn for the duration of the shift and reused after being removed for breaks or eating a meal.
    - The mask will be discarded and replaced when:
        - Visibly soiled
        - It makes direct contact with a resident
        - It becomes so moist/humid that its integrity is affected.
- Whenever a mask is removed, it should be safely stored in a clean, dry paper bag (such as a brown paper lunch bag) clearly marked with the wearer's name.
- For complete details refer to *Masking Protocol for Long Term Care Workers During COVID-19 Pandemic (April 12, 2020)*
- Instructions on universal mask use including a video outlining practices for removing and storing a mask for reuse can be found on NSHA COVID-19 Hub.
- LTCFs should utilize the educational resources available, including proper training in putting on and removing PPE, in order to prevent cross-contamination and the potential spread of infection (refer to attached NSHA signage in Appendix B & C) and the following video.
- Hand hygiene should be performed whenever indicated, paying particular attention to during and after removal of PPE, and after leaving the patient care environment.

In the context of the COVID-19 pandemic and PPE shortages follow jurisdictional and organizational guidance with regard to mask use, reuse, and reprocessing.

Resident Care Equipment

- All reusable equipment and supplies, along with personal belongings, will be dedicated to the use of the resident with or suspected to have COVID-19.
    - If use with other residents is necessary, the equipment and supplies will be cleaned and disinfected before reuse.
- Ensure that any materials (e.g. electronic tablets or other devices, craft supplies, bingo cards, magazines, books, cooking utensils, linens, tools) are not shared among residents unless they are cleaned and disinfected between uses for each resident.
    - If the items cannot be easily cleaned and disinfected, they should not be shared among residents.
- Items that cannot be properly cleaned and disinfected can be dedicated to the resident and then discarded upon resident transfer or discharge.
- At discharge, room transfer, or death of a resident, any resident-owned items (e.g. clothing, photos, televisions, furniture, cards and ornaments) should be removed, any items with hard surfaces cleaned, and items placed in a bag for family or representative.
    - While risk of transmission of COVID-19 via these items is likely low, it is recommended that families store the items for 5 days prior to handling.
    - If the family wishes to donate any of the resident's items to the LTCF or another resident, they must first be thoroughly cleaned and disinfected.
- Discard single-use disposable equipment into a no-touch waste receptacle after use.

Resident Flow and Activity

- All resident flow and activity must comply with physical distancing requirements of 2 metres between residents.
- Symptomatic residents should be restricted to their room and not participate in group activities until symptoms have resolved.
- If residents must leave their room for necessary treatment or transfer, they should wear a procedure mask, perform hand hygiene, and be provided with clean clothes or bedding before leaving the room.
- Distancing measures in LTCFs can include:
    - If there are no cases of COVID-19 identified in the LTCF:
        - Staggering mealtimes if maintenance of this minimum distance can be ensured.
        - Cancellation of any group activities where a minimum 2 metre distance between residents cannot be maintained.
    - If there are suspected or confirmed cases of COVID-19 in the LTCF:
        - Serving residents individual meals in their rooms while ensuring adequate monitoring and supervision for all residents.
        - Cancellation of all in-person group activities.
- Transfer within/to another facility should be avoided unless medically indicated.
- Moving residents while on CPAP or BiPAP within a LTCF should be avoided.

Transfer of Residents

- If it is deemed that a resident with suspected or confirmed COVID-19 should be transferred to an acute care hospital, notification to the facility and EHS of the resident's diagnosis and the need for Additional Precautions is necessary prior to transfer.

Environmental Management

- Environmental services staff should wear the same PPE as other staff when cleaning and disinfecting the resident's room.
- Environmental cleaning products registered in Canada with a Drug Identification Number (DIN) and labelled as a broad-spectrum virucide are sufficient for COVID-19.
    - In the event that commercially-prepared hospital disinfectants are not available, LTCFs may use a diluted bleach solution to disinfect the environment. The concentration of chlorine should be 5000 ppm or 0.5% (equivalent to a 1:9 dilution of 5% concentrated liquid bleach). When using bleach, cleaning must precede disinfection.
- All surfaces or items, outside of the resident room, that are touched by or in contact with staff (e.g., computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) should be cleaned and disinfected at least daily and when soiled.
- All resident room and central area surfaces, that are considered "high touch" (e.g. telephone, bedside table, overbed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet handles and shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser) should be cleaned and disinfected at a minimum of twice daily and when soiled.
    - Hospital grade disinfectant (e.g., disinfectant wipes) using the recommended contact time should be used to disinfect smaller resident care equipment (e.g., BP cuffs,

electronic thermometers, oximeters, stethoscope) after each use.

- Low touch surfaces (e.g., shelves, bedside chairs or benches, windowsills, headwall units, overbed light fixtures, message or white boards, outside of sharps containers) should be cleaned at least once daily.
- Floors and walls should be kept visibly clean and free of spills, dust and debris.
- Toilet brushes, unused toilet paper and other disposable supplies should be discarded. Privacy curtains should be removed and laundered upon a resident's discharge or transfer.
- Environmental cleaning practices are monitored.

Linen, Dishes and Cutlery

- There are no special precautions required for linen, dishes or cutlery. Follow routine practices.

Waste Management

- There are no special precautions required for waste. Follow routine practices.

Management of LTCF Staff Illness or Exposure

Occupational Health, Safety and Wellness works collaboratively with IPAC to identify and mitigate the risk of exposure by performing an organizational risk assessment and ensuring appropriate training of HCWs and staff in LTCF.

- LTCF staff must ensure they are practicing active monitoring for signs and symptoms of COVID-19 on at least a once daily basis.
- Follow directive *COVID-19 Management in Long Term Care Facilities –Directive Under the Authority of the Medical Officer of Health* *
- Staff of LTCFs who become ill with a respiratory infection should report their illness to designated facility Occupational Health professional(s) and follow facility protocols. The facility Occupational Health professional should work collaboratively with the facility management, physician, and public health authorities to manage exposed staff.
- If COVID-19 is suspected or diagnosed in a staff member, case management and return to work should be determined in consultation with the local public health/Medical Officer of Health. Ill staff should not work at any healthcare facility until cleared to return to work.
- LTCFs must ensure clear guidelines and processes are in place for staff who meet the criteria for self-isolation, self-monitoring, work isolation and return to work (RTW) as appropriate to individual scenarios.

Discontinuation of Additional Precautions in Residents

- The duration and discontinuation of precautions in individual residents should be determined on a case-by-case basis, in consultation with the infection prevention and control designate.

Handling Deceased Bodies

- There is no evidence at present of COVID-19 transmission through handling bodies of deceased persons with confirmed or suspected infection. The potential risk of transmission related to this setting is considered low and can be related to:
    - Direct contact with human remains or bodily fluids where the virus is present.
    - Direct contact with contaminated fomites.
- As viable COVID-19 can persist on surfaces for days, it is possible the virus also persists on deceased bodies. Contact with bodies, then, should be avoided by those not wearing PPE. Those in direct contact with deceased cases of COVID-19 (suspected or confirmed) should be protected

from exposure to infected bodily fluids, contaminated objects, or other contaminated environmental surfaces by wearing appropriate PPE.
- Funeral home staff will follow their internal protocols for transport.

Specimen Collection and Testing

- All specimens collected for laboratory investigations should be regarded as potentially infectious, and placed in biohazard bags.
- The LTCF should contact their local PH office/Medical Officer of Health to report the suspect case and discuss clinical assessment and testing of the resident.

Outbreak Management

In the context of the pandemic, a **single** case in a resident or staff with **any** the following symptoms: **fever (temperature of 37.8˚C or greater or signs of fever), cough (new or worsening), sore throat, runny nose, headache, any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise or headache)**] in a LTCF, meets the definition for a 'suspect outbreak' and must prompt outbreak control measures associated with a suspect respiratory infection outbreak.

In the event of a single case, PH will work with facility leadership and/or IPAC designate to manage and implement strategies. These include:

- Immediate notification of any case of influenza-like-illness, including positive COVID-19 test, in residents as outlined in Chief Medical Officer of Health Directive.
- Designated staff should initiate and maintain a line listing of staff with suspected or confirmed COVID-19 as required
- Determination of whether a COVID-19-positive staff member or essential visitor exposed other staff or residents during the period of communicability. Contact tracing of individuals (staff and residents) with potential exposure to the infected individual (either staff or resident).
- Notification of the transferring hospital and local PH authorities if a resident develops symptoms and/or is diagnosed with COVID-19 within 14 days of transfer from another facility.
- Determination of applying outbreak precautions to the affected unit or entire LTCF should be made based on knowledge of the facility and staffing, and in accordance with jurisdictional PH guidance and directives.
- Increased frequency of cleaning with a focus on high-touch surfaces.
- Further restriction of movement of residents within the LTCF, with discontinuation of all non-essential activities, including communal activities.
- Arrange for the use of portable equipment to help avoid unnecessary resident transfers (e.g. portable x-rays), while ensuring that this is cleaned and disinfected between residents.
- Closing the LTCF to new resident admission. Refer to information outlined in the Chief Medical Officer of Health Directive.
- Increased frequency of active screening for COVID-19 symptoms in residents.
- Working with OH and PH for return-to-work policies for staff with COVID-19 whose symptoms have resolved.
- Cohorting of staff and residents is done through consultation with PH authorities and as outlined in *COVID-19 Management in Long Term Care Facilities –Directive Under the Authority of the*

*Medical Officer of Health** (refer to Directive* for full details).

- Residents
  - Residents who are confirmed to have COVID-19 should be placed in alternative accommodation in the home to maintain physical distancing of 2 metres.
  - Resident cohorting of the well and unwell, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate.
- Staff
  - Cohort staff as strictly as possible e.g. staff working with symptomatic residents must avoid working with residents who are well.
  - Staff working within facilities experiencing a COVID-19 outbreak must not work at a non-outbreak facility.
  - If dedicated staff for sick residents is not available, staff must first work with the well/asymptomatic and then move on to care for the ill/symptomatic and avoid movement between floors and units where possible.
  - Staffing challenges may occur as a result of the COVID-19 pandemic, if a LTCF experiences issues with staffing, they should consult PH to consider and review possible approaches and last resort strategies (refer to Directive* for full details).

- Work isolation or work-quarantine is implemented for staff who are asymptomatic but have a high-risk exposure and are deemed a critical staff member (by all parties) to continued operations of the LTCF. In these instances all requirements as set out in the Medical Officer of Health Directive* must be met. These require the staff member to:
  - Be asymptomatic
  - Complete regular twice daily screening of temperature and symptoms
  - Immediately leave the workplace if symptoms develop and self-identify to OHS or supervisor
  - Wear a mask during their shift
  - Wear appropriate PPE when interacting with patients
  - Follow proper hand hygiene protocols
  - NOT work in another facility
  - Maintain self-isolation measures outside of the workplace

Communication

- Leadership of the LTCF will keep residents, family members, and staff informed of presence of COVID-19 within the facility, precautions being taken, visitor restrictions that may be implemented, and who they can contact at the facility for information.

For more information on COVID-19, LTCFs can consult the Nova Scotia Department of Health Coronavirus Webpage, NSHA COVID-19 Hub, or contact their local public health office.

References:

Nova Scotia Department of Health. Coronavirus Webpage

Ontario Ministry of Health and Long-Term Care. Novel Coronavirus (COVID-19) Fact Guidance for Long- Term Care

Public Health Agency of Canada (2020). Infection Prevention and Control for COVID-19: Interim Guidance for Long Term Care Homes

Province of Nova Scotia. (2019). Respiratory Response Plan for Public Health 2019-2020.

Province of Nova Scotia (2019). 2019–2020 Guide to Influenza-Like Illness and Influenza Outbreak Control for Long-Term Care Facilities

Province of Nova Scotia (2020). COVID-19 Management in Long Term care Facilities- Directive Under the Authority of the Chief Medical Officer of Health- revised April 22, 2020

Province of Nova Scotia. (2020). Nova Scotia Interim Guidance: Public Health Measures of cases and contacts associated with Novel Coronavirus (COVID-19)

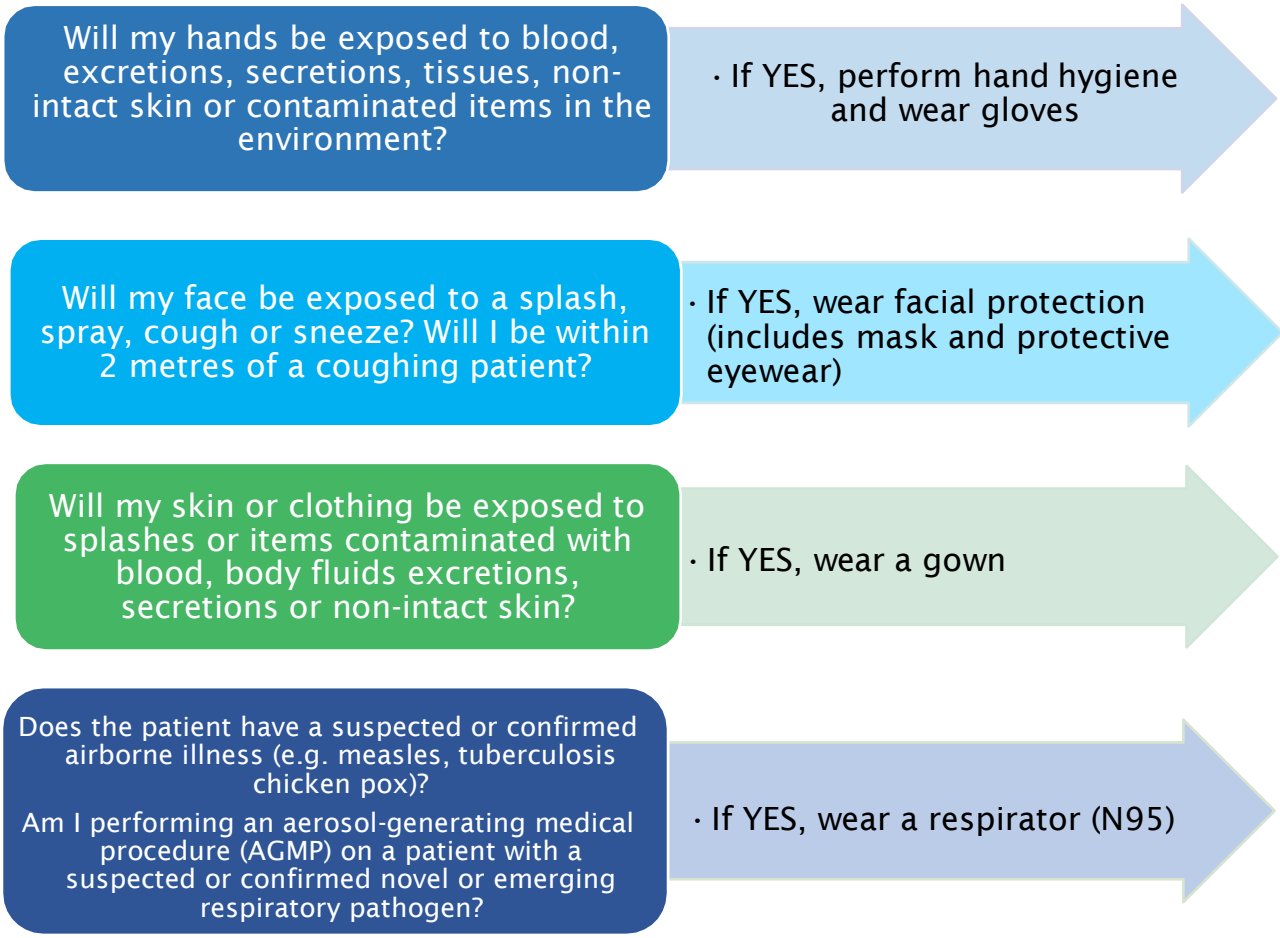
Appendix A- Point of Care Risk Assessment

Point of Care Risk Assessment

Before each patient/patient/client interaction, the health care worker completes a 'Point of Care Risk Assessment' (PCRA) by asking the following questions to determine the risk of exposure and appropriate Routine Practices and Additional Precautions required for safe care:

- **What are the patient's symptoms?**
- **What is the degree of contact?**
- **What is the degree of contamination?**
- **What is the patient's level of understanding and cooperation?**
- **What is the degree of difficulty of the procedure being performed and the experience level of the care provider?**
- **What is my risk of exposure to blood, body fluids, excretions, secretions, non-intact skin and mucous membranes?**

The PCRA allows the health care worker to determine what personal protective equipment (PPE) is selected and worn for that interaction. PCRA is should be performed even if the patient has been placed on Additional Precautions as more PPE may be required.



REMEMBER: Perform Hand Hygiene before and after PPE use.

Appendix B- Guide to Putting on PPE

GUIDE TO PUTTING ON PERSONAL PROTECTIVE EQUIPMENT

Droplet & Contact Precautions (Universal Masking)

1 Procedure/surgical mask

Process will depend on what face/eye protection is available

Scenario 1- If goggles or full-face shield is available, leave mask on and proceed to Step 2.

Scenario 2- If mask needs to be replaced with a mask with visor or N95, perform hand hygiene, remove original mask, and store as per guidance. Proceed to Step 2.

2 Hand Hygiene

Perform hand hygiene.

Alcohol-based hand rub is preferred. Use soap and water if hand are visibly soiled.

3 Long-sleeved gown

- Select level of gown based on fluid exposure risk.
- Make sure the gown covers from neck to knees to wrist.
- Tie at back of neck and waist.

4 N95 Respirator (if applicable)

- Required for AGMPs for patients with unknown, novel or emerging pathogens.
- Refer to manufacturer for specific donning instructions.
- Perform a 'seal check' with each use.
- N95 respirators must be 'fit tested' prior to use.

5 Face/Eye Protection

- Put on mask with visor or goggles or full shield as available.
- Place over the eyes or face.
- Adjust to fit
- **NOTE**: Eyeglasses are not considered protective eyewear.

6 Gloves

- Put on gloves.
- Pull the cuffs of gloves over the cuffs of the gown.

FOR NOVEL AND EMERGING PATHOGENS: Initiate Contact & Droplet Precautions and wear gloves, gowns, procedure/surgical mask and face/eye protection when within 2 metres of patient.

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Appendix C- Guide to Removing of PPE

GUIDE TO REMOVING PERSONAL PROTECTIVE EQUIPMENT

Droplet & Contact Precautions (Universal Masking)

1 Gloves

- Outside of glove is contaminated.
- Use glove to glove, skin-to-skin technique.
- Discard in garbage

2 Hand Hygiene

Perform hand hygiene.

Alcohol-based hand rub is preferred. Use soap and water if hand are visibly soiled.

3 Long-sleeved gown

- Carefully unfasten ties. DO NOT rip off.
- Grasp the outside of the gown at the back by the shoulders and pull down over the arms.
- Turn the gown inside out during removal.
- Carefully fold into bundle.
- Place disposable gown in garbage or place non-disposable gown in laundry hamper.

4 Hand Hygiene

Perform hand hygiene.

Alcohol-based hand rub is preferred. Use soap and water if hands are visibly soiled.

5 Face/Eye Protection

- Handle only by headband or earpieces.
- Carefully pull away from the face.
- Place non-disposable face/eye protection in designated area for disinfection & disposable items in garbage.

6 Mask OR N95 Respirator

Scenario 1- LEAVE MASK ON if wearing full face shield and mask is not visibly soiled or mask integrity is affected by moisture/ humidity. Proceed to Step 7.

Scenario 2: If you wore goggles or wearing mask with visor, mask must be removed. Do not touch front of mask, allow to fall away from face & discard.

N95 must be removed outside of room.

7 Perform Hand Hygiene

8 Exit Patient Room. Remove N95 (if applicable). Perform Hand Hygiene

9 If Applicable, Obtain New Mask or Apply Stored Mask

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