Congregate Living Settings - Recommendations for Cohorting Residents

Introduction

Resident cohorting is the assignment, relocation or movement of two or more residents exposed to or infected with the same laboratory-confirmed pathogen to the same room, treatment space or clinical area. Cohorting is a strategy which can be used when requirements for private rooms exceed capacity.

Cohorting contributes to the control of outbreaks by segregating known infectious residents and should be considered as part of a thorough outbreak management response and surge plan.

Cohorting should occur after all other methods of outbreak management have been implemented and should occur in consultation with residents, families, care teams and the outbreak management team. All efforts to ensure residents are kept in a familiar environment with their belongings and comfort items should be considered.

Residents may remain in their semi-private space while under investigation for viral respiratory illness (VRI,) with droplet and contact precautions in use by all individuals entering that space (otherwise known as "isolation without walls") while maintaining 2 metres of space between bed spaces.

Infection prevention and control (IPC) or the Medical Officer of Health (MOH)/designate shall be included when a decision to cohort is required.

Planning strategy

Comprehensive pandemic planning and emergency preparedness needs to consider the potential requirement to cohort residents during an outbreak management response. Assignment, relocation and movement of residents from their familiar surroundings to a new space has the potential to be traumatic to residents. For more information visit: transfer trauma. Families and residents must be part of the planning process to create awareness and understanding of the need to reduce the risk of transmission while supporting resident care needs. Planning during a pandemic response, where visitor restrictions are in place, should consider other forms of communication with families such as virtual or teleconference.

Planning will also need to consider the resident population, facility size, facility layout and staff compliment. For example, sites of 25 beds or less and/or sites with only semiprivate rooms may not have the space or staffing allocation to relocate residents regardless of how many residents require droplet and contact precautions. Additional consideration should be given to the potential number of affected residents, bed vacancy, mix of bed spaces, surge capacity and staff training related to outbreak management and resident care. Strategies to cohort staff (assign staff to specific areas or residents; ensure staff provide care to **asymptomatic** residents prior to symptomatic) may also need to be considered.

Facility vacancy management

During a pandemic response, vacancy may occur within a facility. In the event that vacancy occurs, assignment, relocation and movement of residents should be considered to reduce the risk of transmission and exposure. For example, if the bed mix includes both private and semi-private spaces, residents who are at higher risk of transmission to others (i.e. currently in a semi-private where one resident is on droplet and

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contact precautions) may benefit from moving to a vacant room. Residents who have aerosol generating medical procedures (AGMP) as part of their care needs may also require a private room.

The utilization of bedside isolation (or isolation without walls) in semiprivate rooms may be disconcerting for residents in the other bed space. Maximizing the use of private bed spaces and consideration of temporary moves to relocate residents that are **suspected**, probable or confirmed together in the same unit or area may reduce the risk of transmission to others. In small sites, or depending on the layout of the facility, there may be no benefit from or ability to cohort residents. Utilization of clinical decision making, evidence-informed practice and collaboration between care teams, residents, families and the outbreak management team (including IPC, the MOH or designate) will be an essential part of determining how to fully utilize any vacancy at your site.

Additional considerations

Accommodation fees for semiprivate and private rooms in designated living options differ. Additional costs may deter residents from choosing private rooms where that choice exists. Most facilities also have extensive waitlists for private rooms. As relocation into private rooms may need to be temporary, it is essential to provide clear written information to residents and families to ensure that there is understanding that COVID related costs will be covered. Additional accommodation fee costs, related specifically to cohorting, should be tracked by the operator as these should be covered as part of the reimbursement of COVID related expenses from the Government of Alberta.

Recommendations

Information on resident assignment, relocation or movement for communicable diseases is found in the AHS IPC Continuing Care Resource Manual.

Cohorting decisions must involve key administrative and clinical leaders in consultation with Infection Prevention & Control (IPC) and / or the Medical Officer of Health (MOH)/designate.

When cohorting is used, **bedside isolation** or isolation without walls is required. This means treating each bed space as a private room.

The following recommendations can be used in the management of isolation residents in AHS continuing care facilities:

- **Residents with more than one transmissible disease/organism are not candidates for cohorting.**
- Adhere to IPC risk assessment, hand hygiene, appropriate use of personal protective equipment (PPE), and appropriate environmental cleaning guidelines.
- Separate resident beds by a minimum of 2 metres.
- Create a visual barrier to define the isolation space(s). A privacy curtain or a portable wipeable screen may be used. Isolated spaces must be treated as though they are a separate room.
- Place dedicated isolation cart at entrance of room/each isolation space. Place the linen hamper and garbage receptacle in close proximity.
- Dedicate resident care items and equipment to each isolated resident if possible. Otherwise, clean and disinfect items before use with any other resident. Shared items that cannot be cleaned/disinfected should be discarded.
- Request that staff follow organizational protocols for isolation/terminal cleaning of the isolation area once a resident has been transferred to a single room or is discharged.
- **When** cohorting, consideration should also be given to:

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  - underlying patient conditions (e.g., immune-compromised, dementia);
  - vaccination status, especially for influenza with respect to co-infection;
  - co-infection with other diseases (e.g. influenza).
- Outbreak measures, such as cohorting, physical distancing in all areas of the facility, isolation of symptomatic residents, outbreak signage posted, enhanced cleaning, strict hand hygiene, restriction of visitors, and cancellation of group activities, apply to the entire facility.

Additional COVID-19 cohorting measures:

- Attempt to move COVID-19 confirmed residents to a private room or cohort with other COVID- 19 confirmed residents in a multi-bed room. Consider risk of exposure and transmission to others when relocating residents to other rooms/areas.
- Follow applicable guidance, such as CMOH orders, for symptom screening, isolation/quarantine and testing of close contacts of suspected, probable or confirmed VRI cases (e.g., roommates and staff).
- Asymptomatic residents should be cared for before those on droplet and contact precautions.
- Attempt to cohort staff: have specific staff only care for those on droplet and contact precautions. Refer to recommendations on staff cohorting.

Refer to the documents on www.ahs.ca/outbreak for detailed information

Please consult with IPC/MOH or designate for your site if you have questions on these recommendations, note increased numbers of symptomatic residents, or require assistance on assignment, relocation or movement of residents with suspected, probable or confirmed VRI.

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