Congregate Living Settings - Recommendations for Staff Cohorting

Applicability

This document is applicable to congregate living setting providers inclusive of long term care, designated supportive living, hospice, personal care homes, and other licensed supportive living settings (e.g. lodge, private supportive living)[i].

Operator applies to any congregate living setting provider inclusive of all of the above settings. This document provides broad evidence-based principles related to infection prevention and control (IPC) and public health (PH). Implementation of these principles will need to occur utilizing clinical judgement and evidence-informed practice considering the multiple implications that size, setting, staff complement and resident population may have on decision-making.

Introduction

Staff cohorting is the assignment of staff to residents or groups of residents based on resident exposure to or infection with the same laboratory-confirmed pathogen. Cohorting is a strategy which can be used to reduce risk of transmission.

Staff who are following hand hygiene guidelines, using appropriate PPE and applying it correctly while caring for residents suspected, probable or confirmed with viral respiratory illness (VRI,) are not considered close contacts and may safely enter public spaces within the facility or other rooms.

Additional restrictions may be in place, based on Chief Medical Officer of Health (CMOH) orders or local Medical Officer of Health (MOH)/designate guidance regarding staff mobility (ability for staff to work at more than one setting).

Planning strategy

Comprehensive pandemic planning and emergency preparedness needs to consider the potential requirement to cohort staff during an outbreak management response. Assignment, relocation and movement of staff should occur in a way that reduces the risk of cross-contamination/transmission to both staff and residents. Designated leaders may want to include families and residents as part of the planning process to create awareness and understanding of the need to reduce the risk of transmission while supporting resident care needs. Consideration should be made to ensure assignment of staff who are familiar with residents and their care needs. Planning during a pandemic response, where visitor restrictions and services reductions may be in place, should also consider additional emotional and social needs of residents and how these will be met with the existing staff model.

Planning will also need to take into account the resident population, facility size, facility layout and staff complement. For example, sites of 25 beds or less may not have the staffing allocation to reassign staff regardless of how many residents require droplet and contact precautions. For larger sites, the utilization of float staff (assigned to provide additional support to multiple care areas or units) may need to be restricted to ensure staff are not moving between symptomatic and asymptomatic[ii] residents. Additional consideration should be given to the potential need for increased educational support for staff during a pandemic. Point in time information will need to be available to ensure staff have the resources and educational materials available for them to make accurate clinical decisions and adhere to infection prevention and control practices, e.g., having buddies assigned to assist with donning and doffing practices, implementation of a PPE Safety Coach Program or having team huddles to discuss any changes in practice.

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Staff vacancy management

During a pandemic response, staff vacancy may occur within a facility. In the event that vacancy occurs, assignment, relocation and movement of staff should be considered to reduce the risk of transmission and exposure to residents. Reduced staffing can increase the risk of transmission as staff are rushed in completing care tasks. Discussions with designated leaders and the outbreak management team will create awareness of staffing issues so that they can be addressed. Many organizations have put forward lists of staffing availability and professional organizations are working to streamline access to registration.

Additional considerations

Ensure staff are utilizing a systematic approach to provide care for asymptomatic residents first, or separately from, care for symptomatic residents. In small sites, or depending on the layout of the facility, there may be no benefit from or ability to cohort staff. Auxiliary hospitals that are attached to acute care facilities may share staff and need to establish additional strategies to reduce risk of transmission. Utilization of clinical decision making, evidence-informed practice and collaboration between care teams, residents, families and the outbreak management team (including IPC, MOH or designate) will be an essential part of determining how to fully utilize staff at your site.

Staff health

Staff are to be “fit to work.” Staff must report symptoms immediately and must not attend to work if they have symptoms. In addition, staff must leave work immediately if they are experiencing symptoms. Team huddles at routine intervals throughout the shift will create an opportunity for staff to re-check for symptoms (as applicable) and will prompt staff to report any symptoms. Follow any recommendations at www.ahs.ca/outbreak regarding staff returning to work in each setting.

Recommendations

Congregate living operators must ensure that they are following all current staffing restrictions and requirements in accordance with any CMOH Orders and organizational guidance.

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

- If symptoms of VRI develop while the staff member is on shift:
  - Site administrators must exclude symptomatic staff from working.
  - Staff must:
    - leave their mask on;
    - notify their supervisor/manager/lead that they report to of their new onset of symptoms;
    - return home and follow outbreak information on when to return to work.

Congregate living operators should assign staff (cohort), to the greatest extent possible, to either:

- Exclusively provide care/service for residents that are asymptomatic (no illness or symptoms of illness), or
- Exclusively provide care/service for residents who are symptomatic (have suspected, probable or confirmed VRI).

When cohorting staff is not possible:

- Minimize movement of staff between residents who are asymptomatic and those who are symptomatic;
- Have staff complete work with asymptomatic residents first before moving to those residents who are symptomatic.

The following recommendations can be used in the management of cohorting staff in congregate living settings:

- Staff with any symptoms are not to attend work and must leave work immediately if they are experiencing any symptoms.
- Adhere to IPC RA Infection Prevention and Control Risk Assessment (IPC RA), hand hygiene, appropriate

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use of PPE, and appropriate environmental cleaning guidelines.

- Follow applicable guidance in CMOH Orders for symptom screening, isolation/quarantine and testing of close contacts of suspected, probable or confirmed VRI cases (e.g., roommates and staff).
- Attempt to cohort residents and have specific staff care for those residents on droplet and contact precautions. Refer to recommendations on resident cohorting.
- Follow IPC Healthcare Attire recommendations
- Follow physical distancing practices and consider modifications to work spaces and common areas (i.e. lunch rooms and locker rooms) to provide a safe working distance (2 metres/6 feet) for staff.

Please consult with IPC and/or the MOH/designate for your site if you have questions on these guidelines, note increased numbers of symptomatic staff, or require assistance on assignment, relocation or movement of staff with suspected, probable or confirmed viral respiratory illness (VRI.)

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[i] **Disclaimer: References to continuing care (including home care, designated supportive living, long term care and hospice) may not reflect the updated language or terms found in the new Alberta Continuing Care Act effective April 1, 2024**.

[ii] **Residents who do not present with any symptoms of viral respiratory illness, or have such mild symptoms they are difficult to detect.**

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