Purpose

The following guidelines provide direction for the safe cohorting of positive or probable COVID-19 positive patients within AHS acute care facilities.

Background

Cohorting is the assignment of a geographic area to two or more patients who are infected with the same pathogen and do not have evidence of co-infection with another pathogen. It can refer to designating a unit or an area within a facility (site-level) or placing two or more patients with same pathogen in a multi-bed room on a unit (unit-level). Principle-based cohorting contributes to the control of outbreaks and should be considered when planning for surge capacity.

Guiding principles

AHS is not considering dedicated COVID-19 hospitals due to the downstream impact to specialty care services and geographic considerations.

Based on site-specific capacity, facility design, and patient population, each site can develop their own cohorting plan using the following guiding principles and considerations:

- The decision to cohort must be made in consultation with IPC.
- A staged approach to cohorting is based on minimizing risk to the most patients while adhering to IPC principles and practices.
- Strict adherence to IPC point-of-care risk assessment, hand hygiene, appropriate use of personal protective equipment (PPE) (donning) and (doffing) by healthcare providers, adequate Spatial Separation and appropriate cleaning and disinfection is required.
- When cohorting patients, consideration should also be given to:
  - underlying patient conditions (e.g., immunocompromised);
  - vaccination status, especially for Influenza with respect to co-infection;
  - co-infection with other diseases (e.g., Influenza).
- Each site/zone should develop decision trees/algorithms based on local infrastructure:
  - Decisions regarding the cohorting of suspected and confirmed (positive) COVID-19 patients versus COVID-19 positive patients only on a dedicated unit.

Cohorting on a unit (small numbers of admitted COVID-19 patients)

Refer to the IPC Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities.
Designated units (large numbers of COVID-19 positive patients)

Having a designated unit may allow for separation of positive or probable COVID-19 patients from other patients within an acute care facility. It may also allow for preservation of PPE amongst healthcare providers and may include the following:

- Consider utilizing areas that have more single-bed rooms.
- Determine how patients with positive or probable COVID-19 will be triaged and admitted.
  - Ideally, cohorting is based on the COVID-19 variant strain.
  - All attempts should be made to use a private room for COVID-positive patients.
- If cohorting is necessary due to capacity challenges, private rooms should be prioritized based on risk.
- Units may be designated as COVID-positive only or mixed COVID-19 confirmed and suspected based on facility infrastructure and local decision-making.
- Units which house both suspected and confirmed COVID-19 patients should use staff cohorting to minimize the risk of transmission.
  - Where staffing levels allow, separate staff groups should care for suspected and confirmed COVID-19 patients.
  - If staffing levels cannot support this, then care should be done in a sequential fashion (care for suspected COVID-19 patients first, then move to positive patients).
- For “Enhanced Environmental Cleaning for COVID-19” - refer to document on Insite.
  
Criteria should be established to move suspected COVID-19 patients who test negative to another space in the facility. *Modified Respiratory or Contact and Droplet Precautions* should be maintained regardless of testing until the patient is assessed using Form 21624 *Discontinuation of Modified Respiratory Precautions for Suspected or Confirmed COVID-19*.

- PPE can be used for multiple patient encounters (refer to next page).

**Additional resources**

1. Infection and Prevention Control (IPC) guidance for cohorting patients in acute care facilities, [Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities](#).
2. IPC guidance for cohorting patients in all congregate living settings in Continuing Care see [Continuing Care Communicable Disease Emergency Response Plan (CDERP) 2016-2017: Treat in Place Guidelines](#).
1. This document provides guidance and recommendations for personal protective equipment (PPE). Each space and flow is different. Contact IPC to discuss site-specific scenarios. Always perform a [Point of Care Risk Assessment (PCRA)] to determine PPE requirements.

2. **Continuous masking:** Use fit-tested N95 respirator.
   - There may be situations where a healthcare worker, based upon their [Point-of-Care Risk Assessment (PCRA)] or their assessment of all known and foreseeable risks and hazards, may choose to wear a medical mask instead of an N95 respirator. See [Joint Statement](#) for more information.
   - Both options are considered safe practice for continuous masking.
   - Use appropriate N95 respirator model/size if fit testing is current (i.e., within the last 2 years) and review the [AHS General Instructions for Putting On and Taking Off an N95 Respirator (Mask)](#) if fit testing is NOT current, then don a well-fitting seal-checked procedure/surgical mask. **A seal check alone is not adequate for an N95 respirator.**
   - Use a well-fitting procedure/surgical mask if fit-tested N95 respirator not available.
   - **Do not double mask** (in any combination of mask and respirator) as there is an increased risk of self-contamination.

3. Use continuous eye protection regardless of HCW vaccination status.

4. HCWs working behind transparent barriers must follow continuous masking and eye protection directives.

5. **Perform hand hygiene** frequently. Do not wear gloves continuously.
   - Gloves do not replace the need for hand hygiene.
   - Gloves cannot be cleaned and become contaminated very quickly.
   - Gloves should be used when handling disinfectants or before contact with body fluids.

6. AHS supplied scrubs may be worn. Must be removed at end of shift and laundered on-site.

7. Extended use of PPE/ PPE-sparing strategies can be considered beyond multi-bed rooms with increased patient load. Please contact IPC before embarking on this strategy.

8. These are interim recommendations and may change with emerging scientific data and evolving epidemiology.
### IPC Cohorting Recommendations for COVID-19 in Acute Care | 4

<table>
<thead>
<tr>
<th>HCW Type Examples</th>
<th>Tasks</th>
<th>Direct patient contact?</th>
<th>Within 2 metres of unmasked patient or contaminated space?</th>
<th>PPE required</th>
<th>When to change</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS HCW/ Contracted HCW/ Volunteers</td>
<td>Staff NOT working within 2 metres of a patient</td>
<td>• If staff are not interacting with patients or contaminated equipment/space, follow <a href="https://www.ahs.ca">continuous masking and continuous eye protection</a> • Use of gowns as per site direction. • Gloves not recommended. Perform hand hygiene frequently.</td>
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<tr>
<td>Protective Services</td>
<td>Unit security within patient care space</td>
<td>Yes or No</td>
<td>Yes or No • Continuous Masking • Continuous Eye Protection • <a href="https://www.ahs.ca">See Personal Protective Equipment – Frequently Asked Questions (PPE FAQ)</a></td>
<td>• Fit-tested N95 respirator o There may be situations where a healthcare worker, based upon their Point-of-Care Risk Assessment (PCRA) or their assessment of all known and foreseeable risks and hazards, may choose to wear a medical mask instead of an N95 respirator. o <a href="https://www.ahs.ca">See Joint Statement</a> for more information. • Eye protection • Gown if blood or body fluid exposure anticipated</td>
<td>Change N95 respirator or well-fitting procedure/surgical mask and eye protection as a unit if: • one or both is wet/soiled • contaminated (e.g. AGMP exposure, coughed or sneezed on) • before breaks and shift change Reusable eye protection must be cleaned and disinfected. Single-use eye protection must be discarded. Change gown if visibly soiled or before breaks/shift change.</td>
<td>• Gloves not recommended. • Perform hand hygiene frequently.</td>
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<td>Unit Clerks</td>
<td>Entering data, clerical duties, coordination of unit activities</td>
<td>Yes or No</td>
<td></td>
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<td>Nursing staff, Nurse Practitioners, Physicians, Unit clerks in direct contact with patients</td>
<td>Patient care</td>
<td>Yes</td>
<td>Yes</td>
<td>• N95 respirator&lt;br&gt;  - There may be situations where a healthcare worker, based upon their Point-of-Care Risk Assessment (PCRA) or their assessment of all known and foreseeable risks and hazards, may choose to wear a medical mask instead of an N95 respirator.  - See Joint Statement for more information.&lt;br&gt;  - Eye protection  - Gown  - Gloves</td>
<td>Change N95 respirator or well-fitting procedure/surgical mask and eye protection as a unit if:  - one or both is wet/soiled  - contaminated (e.g. AGMP exposure, coughed or sneezed on)  - before breaks and shift change  - reusable eye protection must be cleaned and disinfected. Single-use eye protection must be discarded.  - Gloves must be changed between each patient encounter</td>
<td>• Perform hand hygiene frequently.&lt;br&gt;  • Do not wear a procedure/surgical mask over an N95 respirator.&lt;br&gt;  • PPE should always be changed if it becomes visibly soiled.</td>
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<td>Environmental Services</td>
<td>Cleaning of dedicated unit environment</td>
<td></td>
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<td>All Allied Health (including but not limited to Lab, PT, OT, RT, DI, Pharmacy)</td>
<td>Patient care in patient space/room</td>
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