Congregate Living Settings
Recommendations for Staff Cohorting during COVID-19

Applicability

This document is applicable to congregate living settings providers inclusive of long term care and designated supportive living, lodges, group homes, personal care homes, and other congregate living settings.

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 compliment and client population may have on decision making.

Introduction

Staff cohorting is the assignment of staff to clients or groups of clients based on client 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 clients with symptoms of COVID-19, are not considered contacts and may safely enter public spaces within the facility or other rooms. Staff are also required to follow continuous masking guidance.

Any individual (client, staff or designated essential visitor) who has had direct contact with a person who is confirmed for COVID-19, without wearing recommended PPE (i.e., before they are aware that the person is confirmed COVID-19), is required to self-isolate as per the Chief Medical Officer of Health (CMOH) direction.

To protect the most vulnerable Albertans, designated supportive living (DSL) and long term care (LTC) staff are limited to working within one single healthcare facility. This will help to prevent the spread of illness between facilities. This order from the CMOH is inclusive of all staff at the facility (e.g. healthcare workers, food service workers, housekeeping, administrative, home care staff, etc.). The intent of the CMOH order is to limit the risk of transmitting COVID-19 to our most vulnerable by reducing the number of different people that interact with residents. Facility operators, in collaboration with physicians and nurse practitioners, must determine the model of medical care that is appropriate for their clients that minimizes the number of physicians or nurse practitioners physically attending clients in that facility. Physicians and nurse practitioners should provide onsite, in-person care in only one facility, as defined by the order, to the greatest extent possible.

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 the context of trying to ensure that the risk of cross-contamination/transmission to both staff and clients is reduced. Designated leaders may want to include families and clients as part of the planning process to create awareness and understanding of

the need to reduce the risk of transmission while supporting client care needs. Consideration should be made to ensure assignment of staff that are familiar with clients and their care needs. Planning during a pandemic response, where visitor restrictions are in place and services are reduced, should also consider the additional emotional and social needs of clients and how these will be met with the existing staff model.

Planning will also need to take into account the client population, facility size, facility layout and staff compliment. For example, sites of 25 beds or less may not have the staffing allocation to reassign staff regardless of how many clients are requiring contact and droplet 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 clients. 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. For example, having buddies assigned to assist with donning and doffing practices or having team huddles to discuss any changes in practice.

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 clients. 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 that staff are utilizing a systematic approach to provide care for asymptomatic clients first, or separately from, care for symptomatic clients. 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. Utilization of clinical decision making, evidence-informed practice and collaboration between care teams, clients, families and the outbreak management team (including IPC, the MOH or designate) will be an essential part of determining how to fully utilize staff at the site.

Staff health

Staff must complete fitness for work screening. 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. In order to ensure staff are returning to work in a timely manner the return to work guide can assist both staff and operators to determine when staff are fit to return.

Recommendations

Congregate living settings operators must advise staff that they are required to conduct twice daily self-checks (like all Albertans) for signs of COVID-19, for their own health as well as prior to coming to work.

- Any staff member that determines they are symptomatic at any time shall notify their supervisor and/or the facility operator and remain off work for 10 days or until symptoms resolve, whichever is longer, or as per direction of the Chief Medical Officer of Health, or where the staff has had a negative swab and all symptoms have resolved. If symptoms develop while the staff member is on shift, they must notify their supervisor and immediately leave the facility and self-isolate. Refer to Return to Work Guide for additional information.
- Any staff developing symptoms while at work must not remove their mask and must be sent home immediately. Staff must inform all their managers and leads that they report to of their new onset of symptoms.
- Site administrators must exclude symptomatic staff from working.

Congregate living setting operators must ensure that all staff working in DSL and/or LTC are assigned to only one DSL or LTC facility and restricted from working at any other DSL or LTC facility.

- Staff that work at multiple sites must inform their employers immediately and arrange to be assigned to one single site.

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

- Exclusively provide care/service for clients that are asymptomatic (no illness or symptoms of illness); or
- Exclusively provide care/service for clients who are symptomatic (have suspected or confirmed COVID-19).

When cohorting of staff is not possible:

- Minimize movement of staff between clients who are asymptomatic and those who are symptomatic; and
- Have staff complete work with asymptomatic clients first before moving to those clients 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 to work and must leave work immediately if they are experiencing any symptoms.
- Adhere to IPC point-of-care risk assessment, hand hygiene, appropriate use of personal protective equipment (PPE), and appropriate environmental cleaning guidelines.
- For guidance on when to change/remove PPE and perform hand hygiene see Table 1.
- Follow IPC Healthcare Attire recommendations.
- Follow social 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.
- Attempt to cohort clients and have specific staff care for those clients on contact and droplet precautions. Refer to recommendations on client cohorting.
- Refer to the Guidelines for Outbreak Management in Congregate Living Sites COVID-19 for additional information.

Please consult with IPC/MOH or 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 suspect or confirmed COVID-19.

Table 1 – Considerations for PPE utilization when cohorting one or more clients

Proportion of Cases	PPE Use	Recommended Measures	Conservation Strategy
One client with symptoms (as per Resident Daily Screening) or confirmed with COVID-19	Staff should follow continuous masking guidelines in all client care areas and during client care. Clients with symptoms (as per daily resident screening) or confirmed COVID-19 require Contact and Droplet precautions.	Remove gloves, gown, eye protection and mask after caring for clients on Contact and Droplet precautions and don a new mask. All PPE, except for continuous masks, should be removed before entering non-client care areas including charting area where physical distancing cannot be maintained. Implement all conservation strategies.	May wear same mask between asymptomatic clients.
2 or more cases AND Less than 20% of clients have symptoms (as per Resident Daily Screening) or confirmed COVID-19. **For small sites, less than 50 beds, consult IPC or MOH/or designate for guidance on when to cohort and when to enact PPE conservation measures.	Staff should follow continuous masking guidelines in all client care areas and during client care. In consultation with IPC/MOH or designate, consider continuous eye protection (goggles, face shield) for direct client care and when in client care areas. Clients with symptoms (as per Resident Daily Screening) or confirmed COVID-19 require Contact and Droplet precautions.	Remove gloves, gown, and eye protection and mask after caring for clients on contact and droplet precautions and don a new mask when finished the isolated clients care. Do not wear PPE used in rooms of clients on droplet & contact precautions into non-client care areas including charting area. Implement all conservation strategies.	Do not wear gowns, gloves or eye protection for asymptomatic clients unless advised by the IPC/MOH or designate. If clients in same room (multi-bedded room) are suspected or confirmed COVID-19: Gown, mask and eye protection can be worn from client to client in multi-bedded rooms. Gloves must be changed and hand hygiene performed between clients. If PPE is soiled with blood or body fluids it should be changed between clients.
Proportion of clients with symptoms (as per Resident Daily	Staff should follow continuous masking guidelines in all client	If clients in same room (multi-bedded room) are suspected or confirmed	Do not wear gowns, gloves or eye protection for asymptomatic clients

Proportion of Cases	PPE Use	Recommended Measures	Conservation Strategy
Screening) or confirmed clients with COVID-19 is greater than 20% (For small sites, less than 50 beds, consult IPC or MOH/or designate for guidance on cohorting and when to enact PPE conservation measures).	care areas and during client care. In consultation with IPC/MOH or designate, consider continuous eye protection (goggles, face shield) for direct client care and when in client care areas. Clients with symptoms (as per daily resident screening) or confirmed COVID-19 require Contact and Droplet precautions. Roommates of COVID-19 positive cases should be put on Contact and Droplet precautions for 14 days from time of last exposure to a positive case(s).	COVID-19: Gown, mask and eye protection are to be worn from client to client in multi-bedded rooms. Gloves must be changed and hand hygiene performed between clients. Do not wear PPE used in rooms of clients on droplet & contact precautions in non-client care areas, including charting area. Implement all conservation strategies.	unless advised by the IPC/MOH or designate. Continuous use of gowns, masks and eye protection can be worn between clients on Contact and Droplet precautions. Change gloves and perform hand hygiene between all clients, and prior to entering common spaces. Discard PPE when visibly soiled, wet or contaminated with blood or body fluids. Remove PPE at breaks. Don a new masks and eye protection (if applicable) after breaks. Dispose PPE at end of shift. Gloves must be changed and hand hygiene performed between all residents.

Asymptomatic – residents who do not present with any symptoms of COVID-19, or have such mild symptoms they are difficult to detect.