Congregate Living Settings
Recommendations for Staff Cohorting during COVID-19

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).

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[i], probable or confirmed with COVID-19, are not considered close contacts and may safely enter public spaces within the facility or other rooms. Staff are required to follow AHS *Use of Masks During COVID-19* Directive.

Refer to COVID-19 Prevalence Testing and Screening: Non-Designated Supportive Living (NDSL) and COVID-19 Prevalence Testing and Screening - DSL, LTC & Hospice.

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). Follow applicable guidance in CMOH Orders or COVID-19 orders and legislation for applicable guidance.

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 modified respiratory 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. For example, 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.

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 must complete Fit for Work screening using the most up-to-date and correct screening tool for the setting. 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 Decision Chart can assist both staff and operators to determine when staff are fit to return.

Recommendations

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

Refer to the following documents for detailed information:

- Alberta Public Health Disease Management Guidelines: Coronavirus - COVID-19
- Guide for Outbreak Prevention and Control in Non-Designated Supportive Living Sites
- Guide for Outbreak Prevention and Control in Long Term Care and Designated Supportive Living Sites

Congregate living operators must advise staff that they are required to conduct Fit for Work screening prior to coming to work, and monitor for signs of COVID-19 throughout their shift.

- Any staff member that determines they are symptomatic at any time shall notify their supervisor and/or the facility operator, remain off work, and isolate as per the current CMOH Orders and applicable organizational guidance (e.g. AHS Attending Work with COVID-19 Symptoms, Positive Test or Close Contact Policy).

- If symptoms 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 isolate; and
          use the AHS Online Assessment Tool or call Health Link (811) to receive additional information on testing and isolation.

Congregate living operators must 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 COVID-19).

When cohorting of staff is not possible:

- Minimize movement of staff between residents who are asymptomatic and those who are symptomatic, and
- 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 to work and must leave work immediately if they are experiencing any symptoms.
- Adhere to IPC Point of Care Risk Assessment (PCRA), hand hygiene, appropriate 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 COVID-19 cases (e.g., roommates and staff).
- Attempt to cohort residents and have specific staff care for those residents on modified respiratory 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.

- Fully immunized staff who are required to wear a mask following their shortened isolation period CANNOT remove their mask for any purpose (including eating and drinking). Workers should be provided with a private space to eat. If needed, staff can cohort together for meals and breaks in the same well-ventilated room. Distancing is recommended and individuals should remain masked at all times when not actively consuming food and drink.

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 COVID-19.

Initiate PPE conservation strategies in consultation with IPC and/or MOH/designate.

[i] **Suspected** - management of suspected cases of COVID-19 is consistent with the management of probable cases of COVID-19 in alignment with the definitions set out in the Public Health disease management guidelines: coronavirus – COVID-19 - Open Government (alberta.ca).

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