

# Shelter Spaces and Pandemic Response

A Best Practices Handbook for Flexible  
Space Planning

“We had the opportunity to create an intentionally designed community space with an emergency shelter as part of it. She has been a gift to every part of healing, dignity, play and joy for the team, for women and children who stay there and for our community who continues to come in every day. She’s intentionally built. She has love at her foundation, she has welcome in her wealth and she has risen again and again and again [...] Architecture matters greatly.”

- Focus Group Participant

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# **Executive Summary**

**Purpose:** This Handbook presents an analysis of the impact of COVID-19 on the physical spaces of Ontario gender-based violence/violence against women shelters. Based on our analysis, suggestions are provided for shelters on how to adapt both their pandemic protocols, and their spaces, to ensure more flexibility for events requiring physical distancing and other spatial changes.

**Approach:** 15 Ontario shelters of various sizes and configurations and located in urban, rural and remote locations provided floor plans and/or COVID-19 protocols. We first examined overall net space loss due to physical distancing and service restrictions, and how the layout of bedrooms and bathrooms affects the number of people that can stay or be admitted to shelter. We then examined the spaces according to function: across all kinds of shelters, about 25% of their space was Primary (bedrooms, bathrooms, washrooms, and laundry); 30% was Secondary (communal and office spaces), and 45% was Tertiary (circulation and storage spaces). We further analyzed the impact of the bedroom to bathroom ratio and layout of the shelters relative to space loss and functionality. See Appendix A for more information.

**Findings:** On average shelters suffered a 27% loss of space due to COVID-19 protocols, with a range of 7%-56%. The space loss for each category was calculated to determine not only how much overall space was lost due to the new restrictions, but what kind of space shelters no longer had access to, creating an idea of what aspects of shelter services were also lost. The average space loss per category was:

- Primary Spaces: 18% lost
- Secondary Spaces: 48% lost
- Tertiary Spaces: <1% lost

Although there was some variation in how the space was broken down, it was not dependent on the size or the location of the shelter.

Analysis of bedroom to bathroom ratios found that the number of bathrooms already available had a large impact on how many beds could remain in use. Some shelters chose to maintain single-family bathroom use and close bedrooms; others chose to increase cleaning in shared bathrooms where single occupancy was impossible. Details and visuals of how different decisions impacted space and function are provided in the Handbook.

**Interpretation:** Most shelters saw important reduction in their Primary spaces, and a major reduction in their Secondary spaces. The loss of Secondary space was mainly due to the combination of staff working from home and closing the on-site offices, and the closure of most community spaces, including kitchens, dining, and living spaces.

Some shelters lost more space than others, with the differences due in part to the physical layout of the shelter, especially the ratio of bedrooms to bathrooms, the overall size of the space and their ability to physical distance, etc., and in part to the stringency of safety measures required by local Public Health officials. Specifically, the Ministry of Health required a one-step approach, adopted by 12 of the 15 participating shelters, that immediately requires shutting down communal spaces and requiring women and families to stay in their rooms for the majority of their stay in shelter. An alternative approach, used by 3/15 shelters, was more context-specific, using consultation with Public Health about community levels of risk and a series of “if, then” statements to guide protocols. Shelters implementing the latter approach fared somewhat better in terms of space loss. Our companion qualitative research with shelter staff, leaders and women identified concerns about the “one-step” approach, including the negative effects of isolation in bedrooms, rules that were unevenly applied among women based on their specific characteristics and circumstances and/or were difficult to enforce, and concerns that the stringency of these requirements was itself

controlling to the extent that women were further triggered and harmed by the rules themselves.

The most flexible option was an existing one bedroom with one adjoining bathroom layout, as no increased cleaning or room closures were needed to maintain single occupancy. However, because this is the most expensive option, many shelters had a two-bedroom to one-bathroom ratio, or a dorm style layout where multiple bedrooms shared a single bathroom. In these shelters, room closures were generally required.

**Recommendations:** Finally, the Handbook lays out a series of recommendations, based on our analyses, for New Builds, Renovations, and Immediate Work-Arounds.

New Builds:

- build at least one one-bedroom with an adjoining bathroom that could serve as a quarantine unit;
- build a commercial kitchen separate from the communal kitchen that would ensure a chef/cook position within the shelter and make it easier for single-serving meal preparation.

Renovations:

- build as many new bathrooms as possible within the budget. This would ensure more flexibility and fewer room closures by reducing the ratio of bedrooms to bathrooms;
- build an outdoor space that could be used to hold face-to-face outreach meetings in the warmer months.

Immediate Work-Arounds:

- place tape on the floors and/or move furniture around to provide visual cues for physical distancing;
- combine adjoining rooms instead of closing one to create larger spaces for women and families who need to isolate.

This analysis demonstrates the significant impacts that COVID-19 has had on shelter spaces, and services. It shows that no matter the size or location of the shelter, gender-based violence/violence against women shelters were not designed to thrive under the public health directives of a pandemic. In the first instance we hope that the recommendations provide some guidance for immediate ways to offset some of the worst impacts and support better experiences of service for women and staff. Going forward, these results can be used to advocate for public health protocols that better align with the values of gender-based violence/violence against women shelters including supporting the funding of renovations that create more flexible spaces for future crises.

**Suggested Citation:**

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# Main Findings

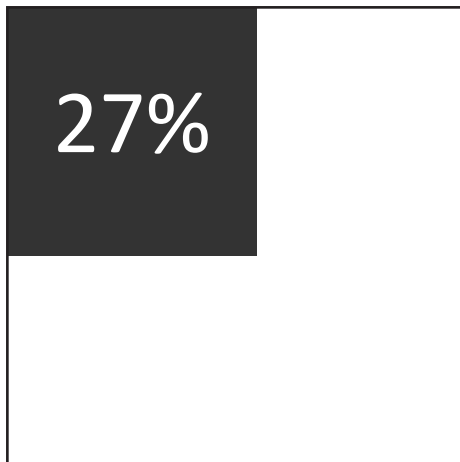
“Our ministry gave us some pretty distinct rules about who was able to come in and out of our emergency shelter. That made it difficult because in our emergency shelter we also have office space that then we weren’t able to access, so we’ve had to move several people to remote working.”

- Focus Group Participant

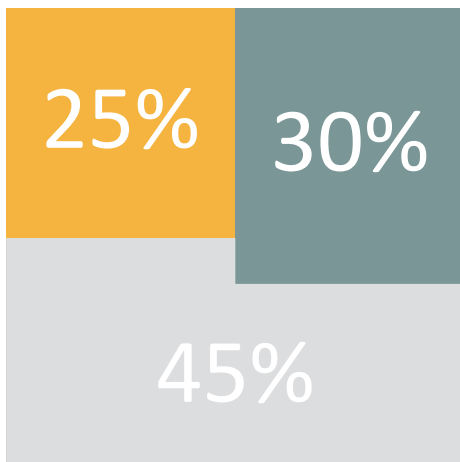


## A Brief Overview of the Data

Data includes 15 gender-based violence/violence against women shelter floor plans from across Ontario. It represents shelters of all sizes in urban, rural, and remote communities.



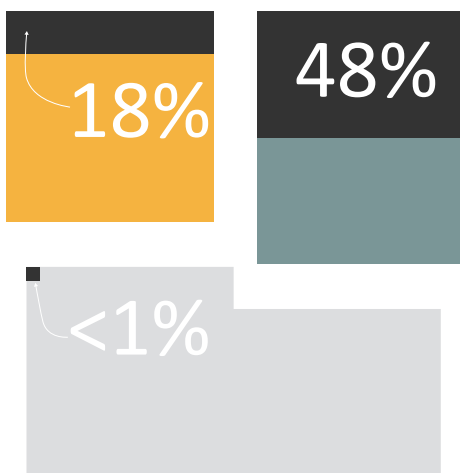
Of the analysed shelters, all lost some amount of space due to new COVID-19 pandemic protocols. This loss ranged from 7%-56% of the shelter's net floor area, depending on what public health guidance was followed. On average 27% of shelter space was lost, with a median loss of 20%.



The analysis of these floor plans included studying what kinds of space each shelter contained, breaking them down into three (3) categories:

1. Primary Space (bedrooms, bathrooms, washrooms, and laundry areas)
2. Secondary Space (community spaces and offices, including kitchen and dining spaces)
3. Tertiary Space (circulation and storage spaces)

The diagram to the left shows the average breakdown of these categories.



Given the two metrics above, the amount of space loss per category was also calculated. The breakdown is as follows:

1. Primary Space: almost all of this loss was due to the closure of bedrooms because of public health restrictions on sharing bathrooms
2. Secondary Space: closures of kitchen, dining, and living areas were often mandated accounting for much of this loss; also takes into account the closure of offices as people shifted to working from home
3. Tertiary Space: most circulation and storage spaces remained open as they were deemed either low-risk or increased cleaning was sufficient for infection control

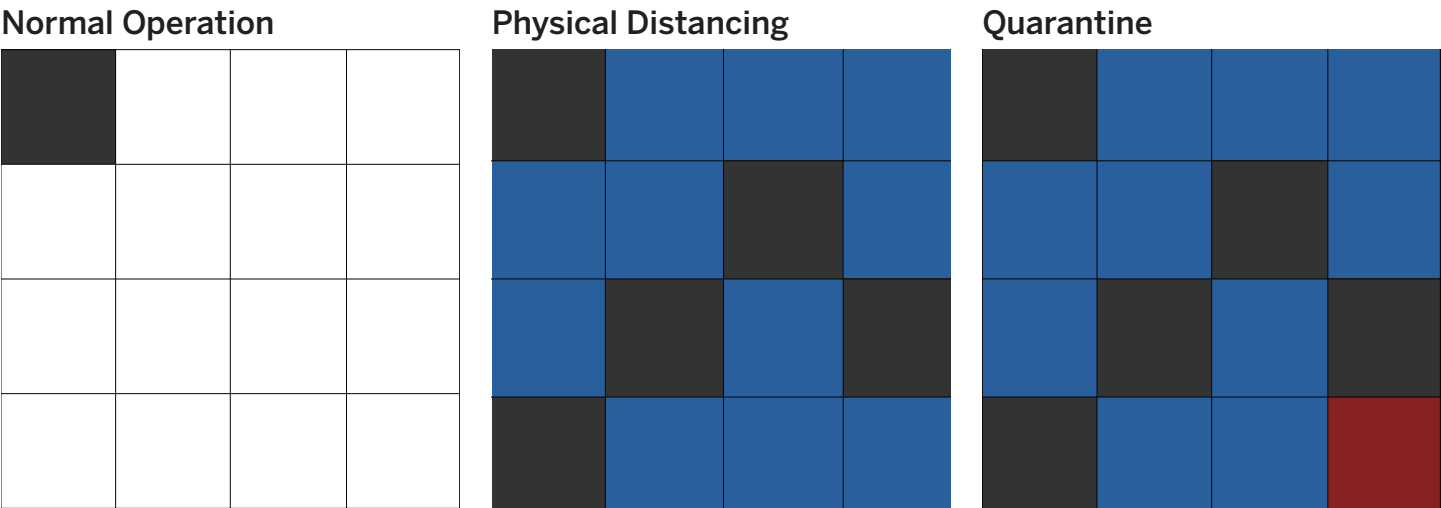
# Protocol Analyses

“We have seen lots of folks coming - looking for shelter space, but, again, the need to isolate as per the directives created significant barriers for women when they’re coming in and they’ve been exposed to trauma. And the idea of being isolated in their room for 14 days for symptom identification and pre-screening, unfortunately, created a lot of barriers, and some women said they weren’t comfortable doing that. They didn’t want to commit to shelter and then have to be isolated. So, some of the orders and some of the directives really, from a trauma and violence informed perspective, didn’t necessarily always meet the needs of the women that we were supporting.”

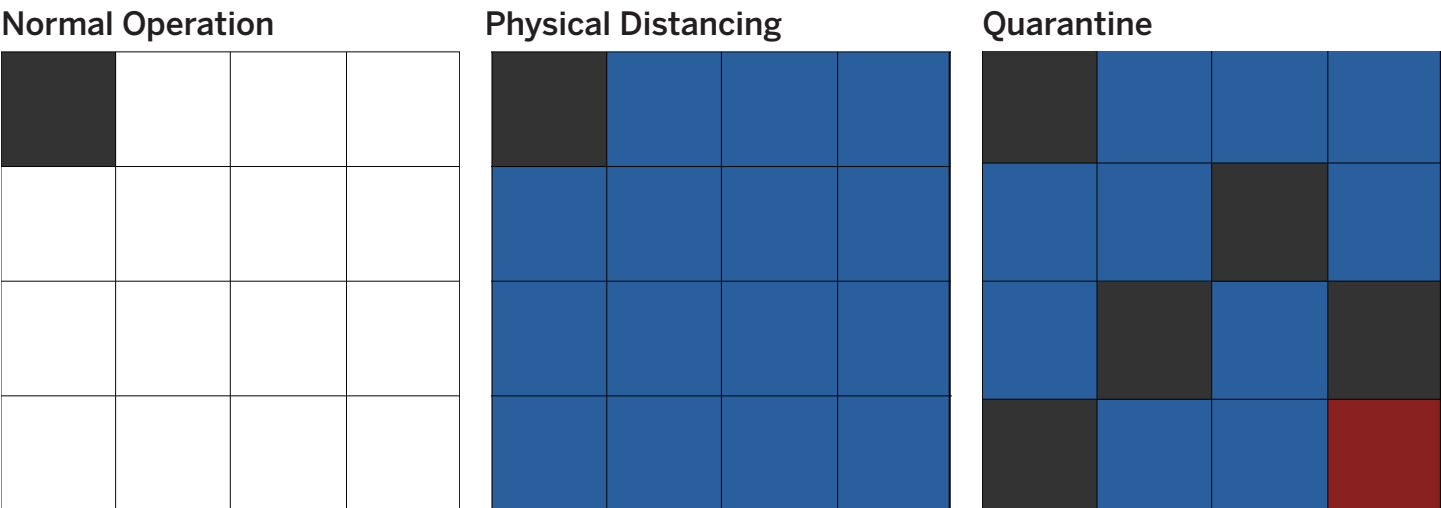
-Staff Interview Participant

The following pages include generic floor plans for different shelter types. They depict an overall breakdown of space types - Primary, Secondary, and Tertiary - as well as how the space reacts under two kinds of pandemic protocols. These two kinds of protocols were selected based on the 15 collected for this study. They include a One-step protocol (see Appendix B) and a Multi-step protocol (see Appendix C).

A One-step protocol acts to control disease spread by shutting down high-risk areas - communal spaces including kitchen, dining, and living rooms - from the beginning of a pandemic, regardless of the situation within the shelter.



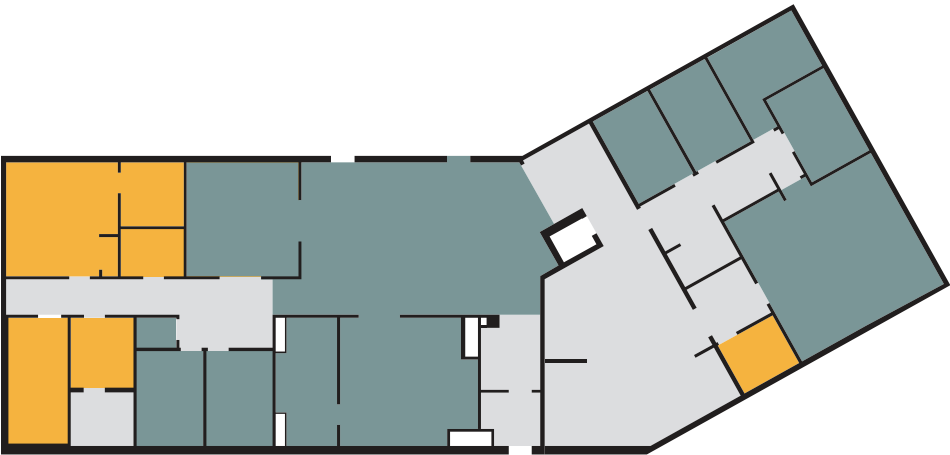
A Multi-step protocol has a series of “if...then” steps in place that take into account the context within the shelter. While it maintains the same level of rigorous cleaning from the beginning of the pandemic, it takes a more context-specific approach, reducing the amount of time women and families spend in isolation, without communal space.



In the examples that follow the overall space loss between both One-step and Multi-step protocols stay the same, as they have been applied to the same spaces, but they act to visualize the difference in space, and therefore service, that might occur in both scenarios.

# Small, Single Storey Shelter Example

## General Space Breakdown



**% Total Accessible SQFT**  
100 %

**% Primary Space**  
22.2 %

**% Secondary Space**  
50.1 %

**% Tertiary Space**  
27.7 %

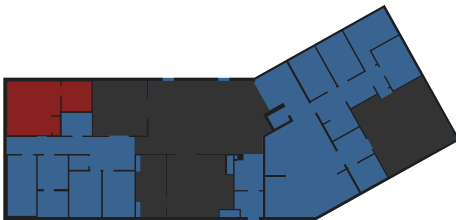
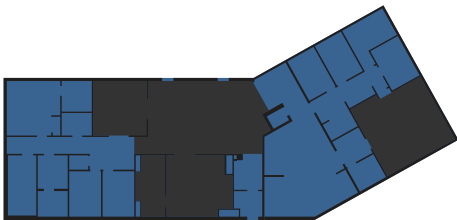
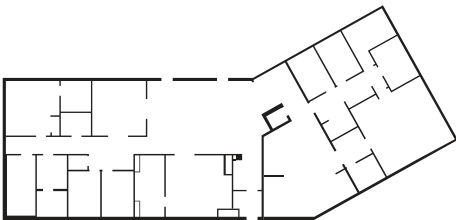
**One-Step Protocol**  
% Space Loss during P.D.  
36.0 %  
% Space Loss during Q.  
0.0 %

**Multi-Step Protocol**  
% Space Loss during P.D.  
0.0 %  
% Space Loss during Q.  
36.0 %

**One-Step Protocol**  
Normal Operation

Physical Distancing

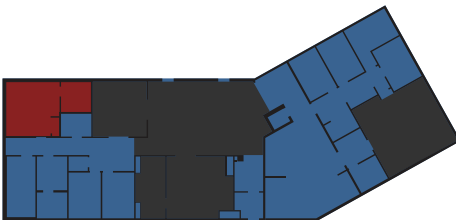
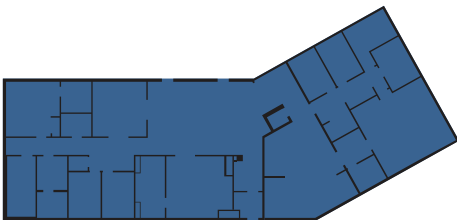
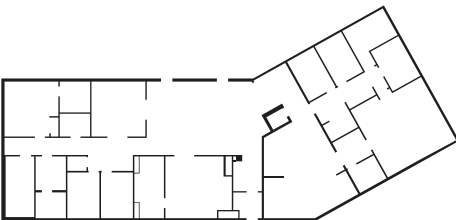
Quarantine



**Multi-Step Protocol**  
Normal Operation

Physical Distancing

Quarantine



# Medium, Single Storey Shelter Example

## General Space Breakdown



**% Total Accessible SQFT**

97.8 %

**% Primary Space**

17.0 %

**% Secondary Space**

52.6 %

**% Tertiary Space**

28.3 %

**One-Step Protocol**

% Space Loss during P.D.

33.2 %

% Space Loss during Q.

0.0 %

**Multi-Step Protocol**

% Space Loss during P.D.

6.1 %

% Space Loss during Q.

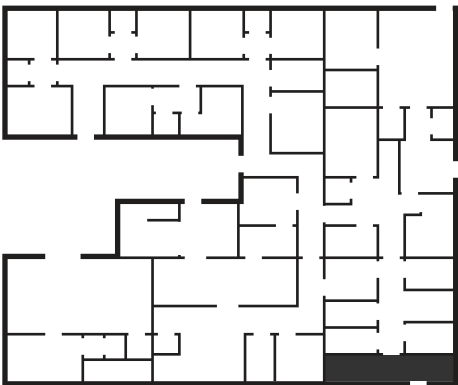
27.1 %

## One-Step Protocol

Normal Operation

Physical Distancing

Quarantine

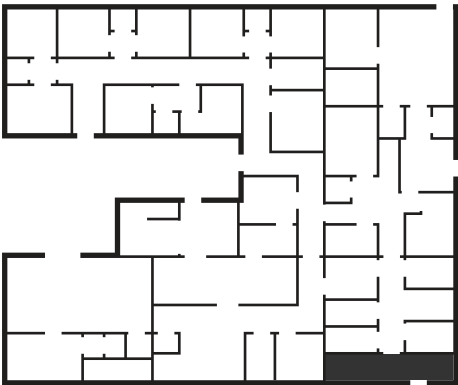


## Multi-Step Protocol

Normal Operation

Physical Distancing

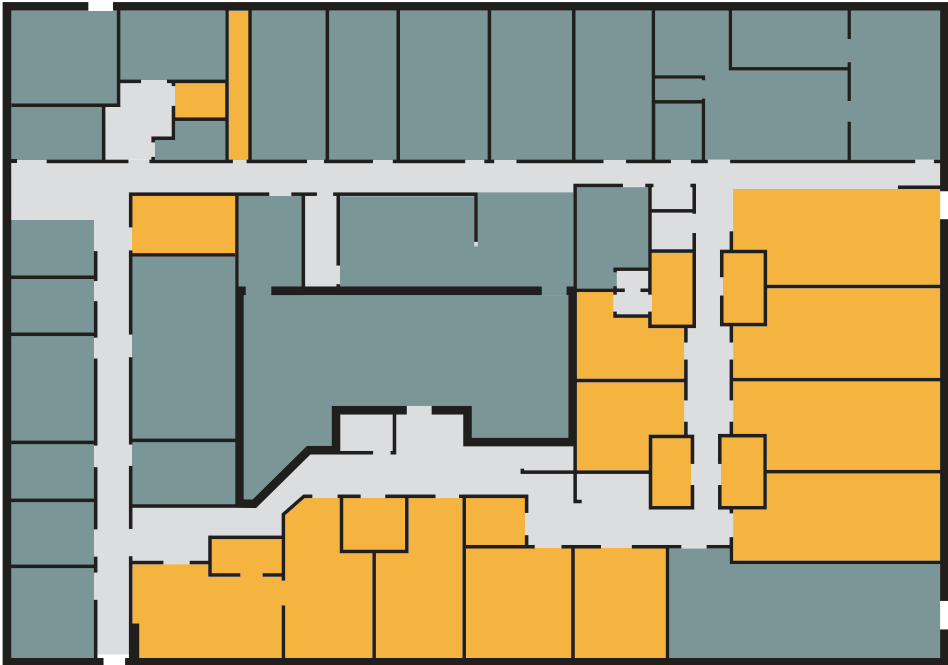
Quarantine



■ No Access ■ Increased Cleaning ■ Quarantined Space ■ Primary Space ■ Secondary Space ■ Tertiary Space

# Large, Single Storey Shelter Example

General Space Breakdown



<b>% Total Accessible SQFT</b>	99.7 %
<b>% Primary Space</b>	24.2 %
<b>% Secondary Space</b>	39.9 %
<b>% Tertiary Space</b>	13.7 %
<b>One-Step Protocol</b>	
% Space Loss during P.D.	17.6 %
% Space Loss during Q.	0.0 %
<b>Multi-Step Protocol</b>	
% Space Loss during P.D.	5.4 %
% Space Loss during Q.	12.2 %
Quarantine	

One-Step Protocol

Physical Distancing

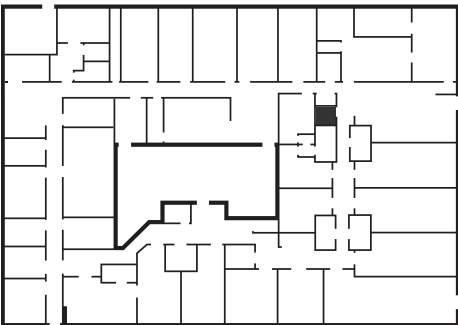
Quarantine



Multi-Step Protocol

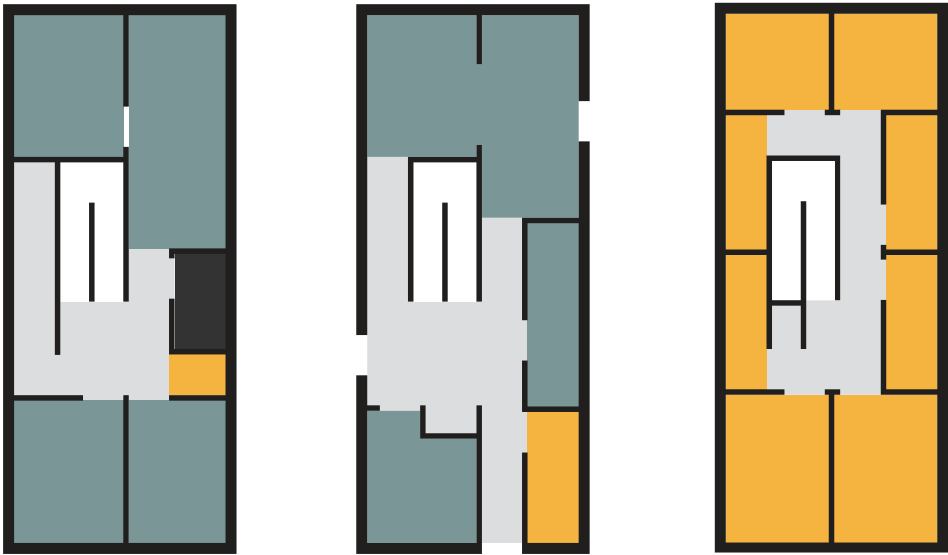
Physical Distancing

Quarantine



# Small, Multi-Storey Shelter Example

## General Space Breakdown



**% Total Accessible SQFT**

98.3 %

**% Primary Space**

28.8 %

**% Secondary Space**

43.0 %

**% Tertiary Space**

26.4 %

**One-Step Protocol**

% Space Loss during P.D.

36.6 %

% Space Loss during Q.

0.0 %

**Multi-Step Protocol**

% Space Loss during P.D.

13.3 %

% Space Loss during Q.

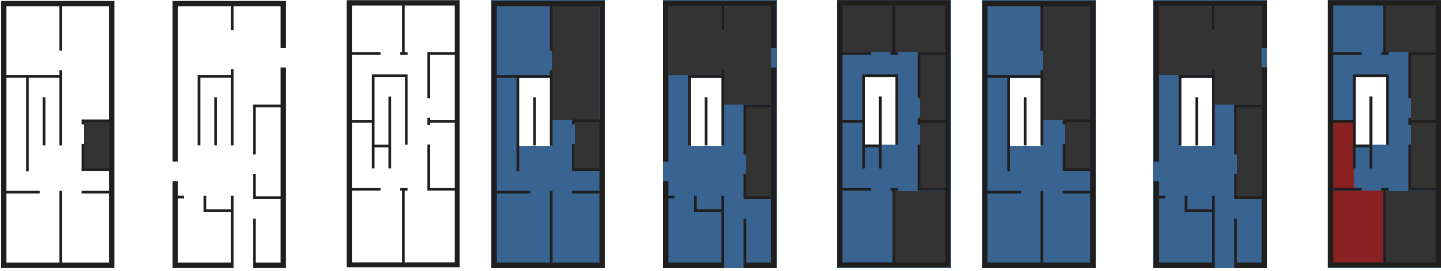
23.2 %

**One-Step Protocol**

Normal Operation

Physical Distancing

Quarantine

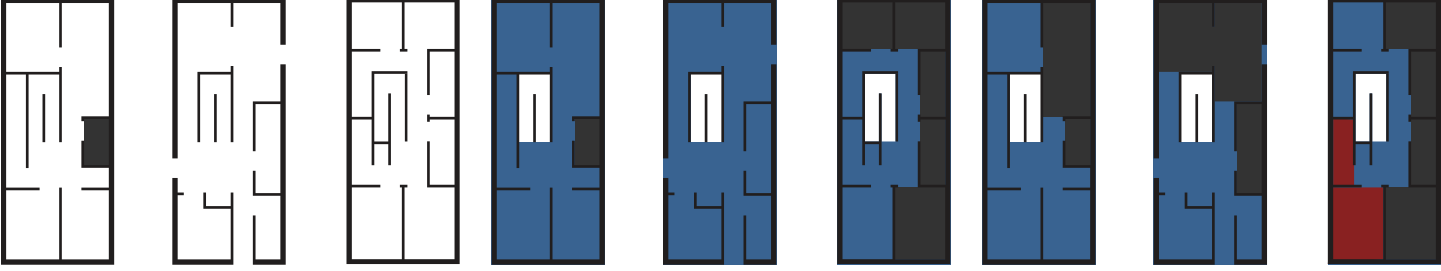


**Multi-Step Protocol**

Normal Operation

Physical Distancing

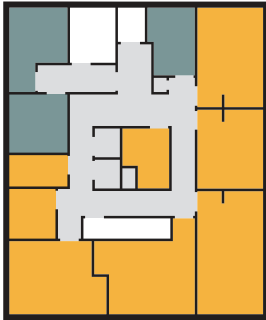
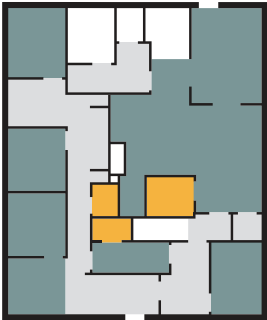
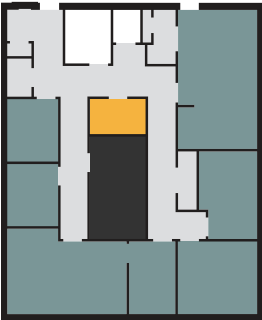
Quarantine



■ No Access ■ Increased Cleaning ■ Quarantined Space ■ Primary Space ■ Secondary Space ■ Tertiary Space

# Medium, Single Storey Shelter Example

## General Space Breakdown



**% Total Accessible SQFT**

97.8 %

**% Primary Space**

21.7 %

**% Secondary Space**

44.5 %

**% Tertiary Space**

27.7 %

**One-Step Protocol**

% Space Loss during P.D.

44.6 %

% Space Loss during Q.

0.0 %

**Multi-Step Protocol**

% Space Loss during P.D.

13.6 %

% Space Loss during Q.

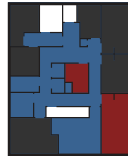
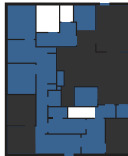
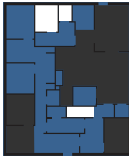
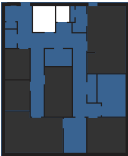
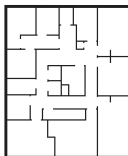
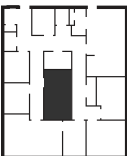
31.0 %

**One-Step Protocol**

Normal Operation

Physical Distancing

Quarantine

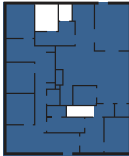
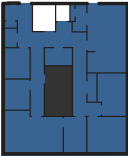
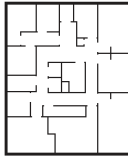
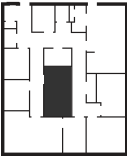


**Multi-Step Protocol**

Normal Operation

Physical Distancing

Quarantine

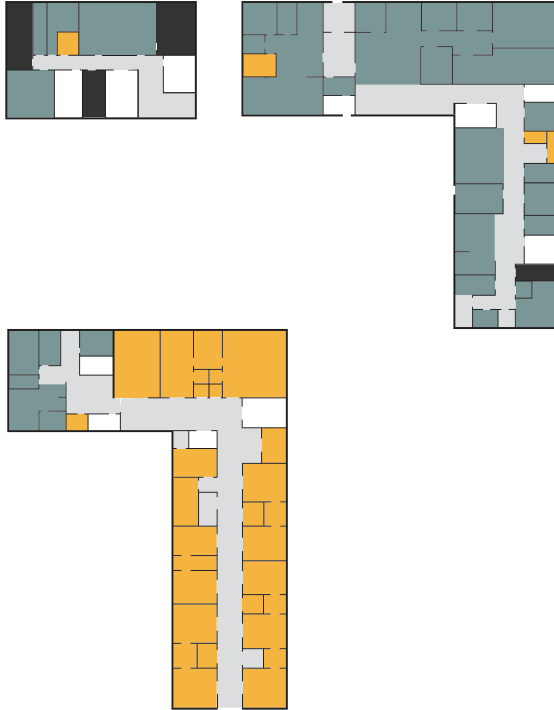


■ No Access ■ Increased Cleaning ■ Quarantined Space ■ Primary Space ■ Secondary Space ■ Tertiary Space



# Large, Multi-Storey Shelter Example

## General Space Breakdown



## % Total Accessible SQFT

95.7 %

## % Primary Space

27.4 %

## % Secondary Space

41.7 %

## % Tertiary Space

26.6 %

## One-Step Protocol

% Space Loss during P.D.

19.7 %

% Space Loss during Q.

0.0 %

## Multi-Step Protocol

% Space Loss during P.D.

6.1 %

% Space Loss during Q.

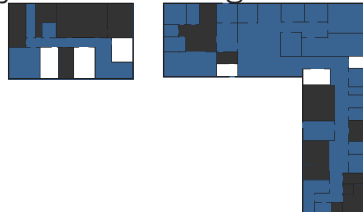
13.5 %

## One-Step Protocol

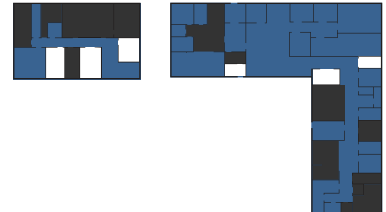
### Normal Operation



### Physical Distancing

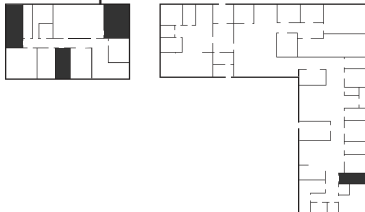


### Quarantine

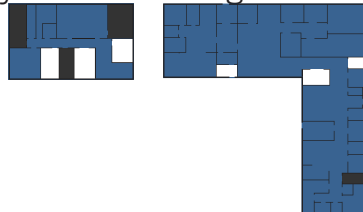


## Multi-Step Protocol

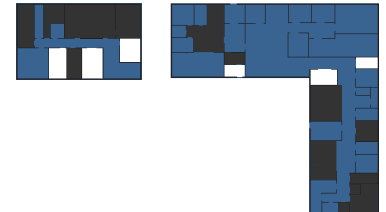
### Normal Operation



### Physical Distancing



### Quarantine



No Access
  Increased Cleaning
  Quarantined Space
  Primary Space
  Tertiary Space

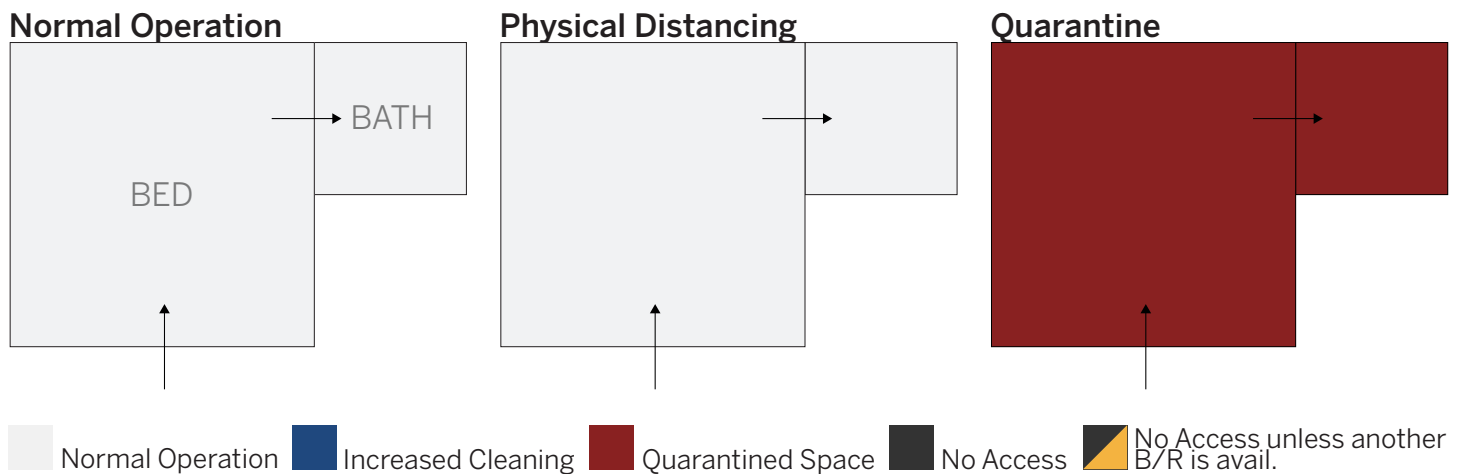
# Bedroom Layouts

“I think we’re going to have to just make some future plans in terms of creating more bedroom space and things like that if we want to keep our capacity the same.”

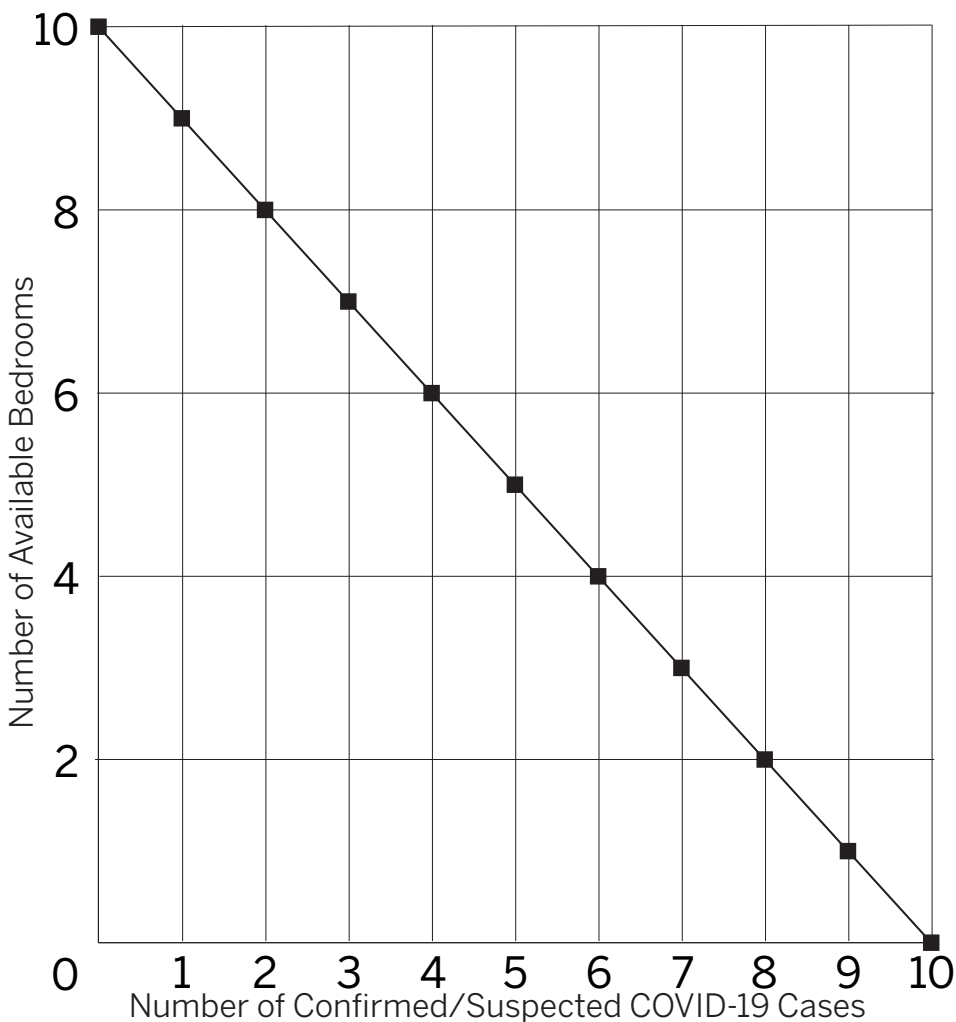
- Focus Group Participant

# One (1) Bedroom to One (1) Bathroom

This layout is optimal to ensure flexibility in a pandemic. It isolates quarantine conditions without impacting any other bedrooms or bathrooms. However, it is the most expensive option for a new build or renovation. See Page 24.



## Available Bedrooms due to the Number of Confirmed/Suspected COVID-19 Cases in a Shelter with One (1) Bedroom to One (1) Bathroom

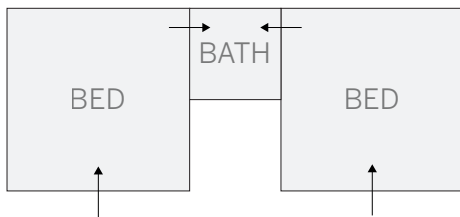


In a shelter with 10 bedrooms, 10 suspected/confirmed cases are required before all residential services are lost.

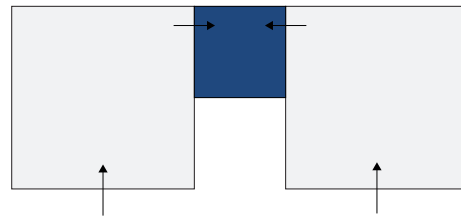
## Two (2) Bedrooms to One (1) Bathroom with an Interior Entrance

This 2:1 Bed to Bath layout, more commonly known as “Jack and Jill style” joins two rooms through the bathroom. Because of this shared space, one of the bedrooms will be lost under quarantine conditions, unless this space is shared by one family. Refer to Page 27 for renovation recommendations.

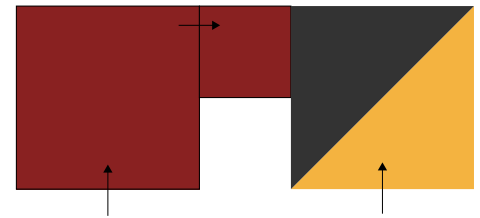
**Normal Operation**



**Physical Distancing**

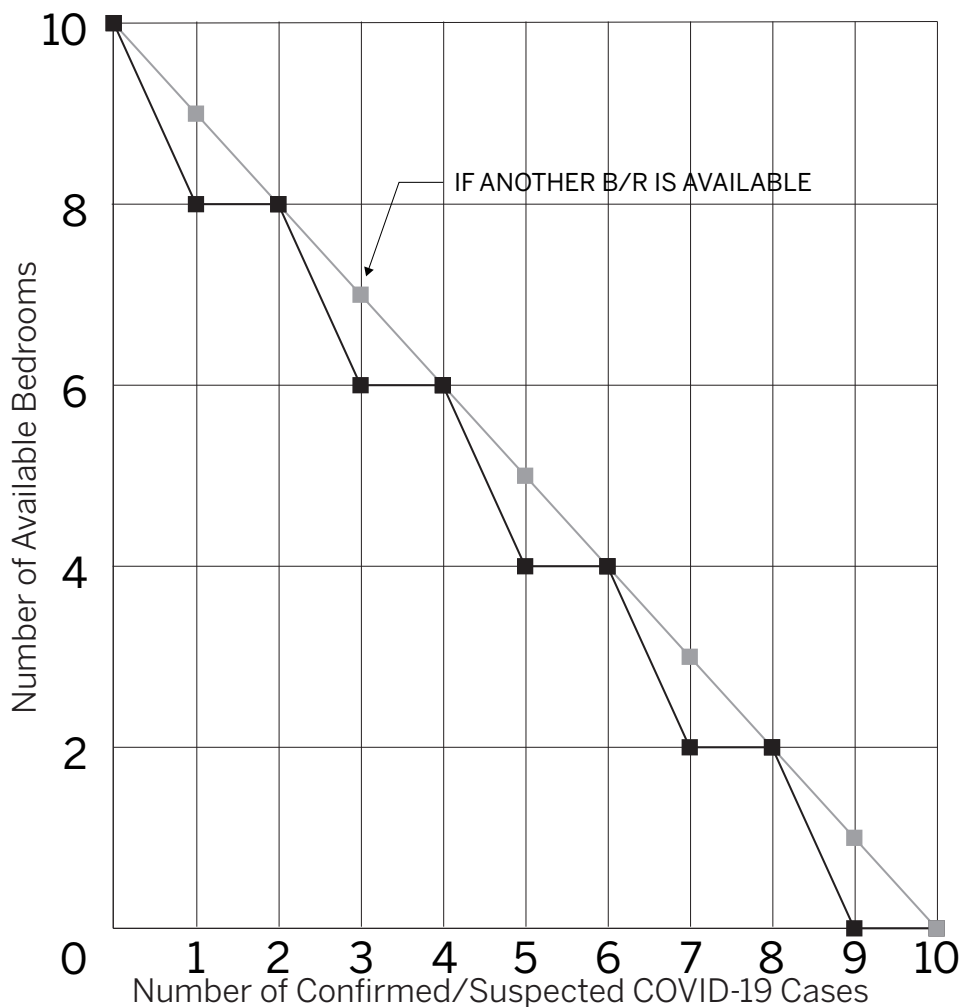


**Quarantine**



Normal Operation
  Increased Cleaning
  Quarantined Space
  No Access
  No Access, unless another B/R is avail.

**Available Bedrooms due to the Number of Confirmed/Suspected COVID-19 Cases in a Shelter with Two (2) Bedrooms to One (1) Bathroom**

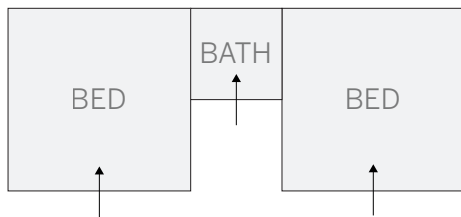


In a shelter with 10 bedrooms, 9 suspected/confirmed cases are required before all residential services are lost, unless extra bathrooms are available. This assumes that confirmed cases would be cohorted in adjoining bedrooms to maintain as many other open beds as possible.

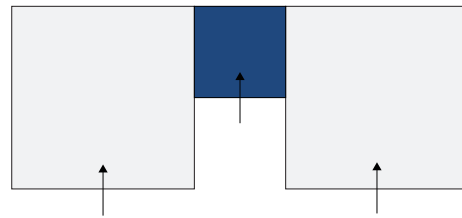
## One (2) Bedrooms to One (1) Bathroom with an Exterior Entrance

Like the last example, this layout shares one bathroom between two bedrooms. The difference here lies in the fact that the entrance to the bathroom is accessed through the hallway. This exterior entrance allows for more flexibility if bathroom assignments need to be rearranged (e.g. if a bedroom must be quarantined, the second bedroom can easily access a different bathroom off the hallway, if available.). See Pages 25 and 26.

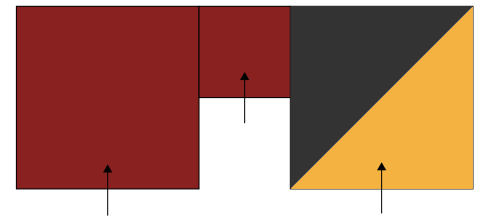
### Normal Operation



### Physical Distancing

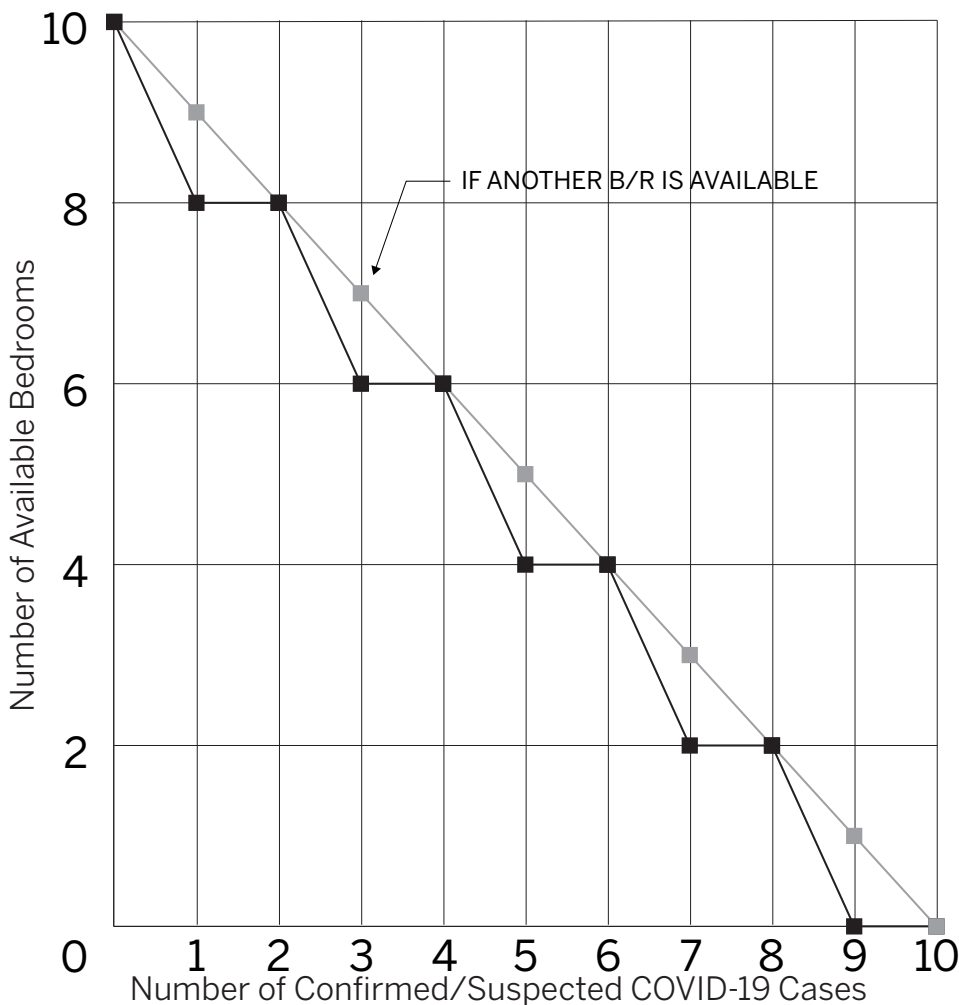


### Quarantine



Normal Operation
  Increased Cleaning
  Quarantined Space
  No Access
  No Access, unless another B/R is avail.

### Available Bedrooms due to the Number of Confirmed/Suspected COVID-19 Cases in a Shelter with One (1) Bedroom to One (1) Bathroom

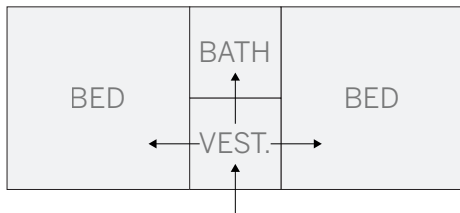


In a shelter with 10 bedrooms, 9 suspected/confirmed cases are required before all residential services are lost, unless extra bathrooms are available. This assumes that confirmed cases would be cohorted in adjoining bedrooms to maintain as many other open beds as possible.

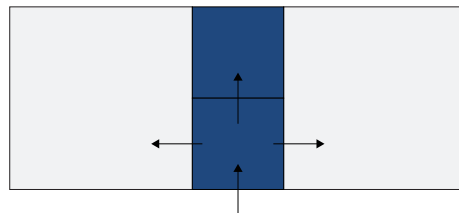
## Two (2) Bedrooms to One (1) Bathroom with a Vestibule

Similar to the last two layouts, this example has a 2:1 bed to bath ratio. However, the addition of the vestibule complicates things in a pandemic. Because the vestibule is a shared space, it makes it impossible to safely house another woman/family in the second room. Even if another bathroom was available, the transition between the bedroom and bathroom through the vestibule means all three of these spaces must be considered as the quarantined space.

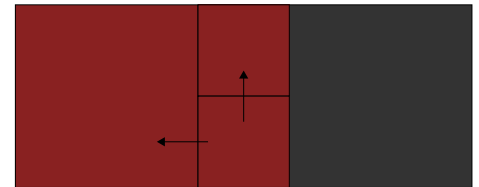
### Normal Operation



### Physical Distancing

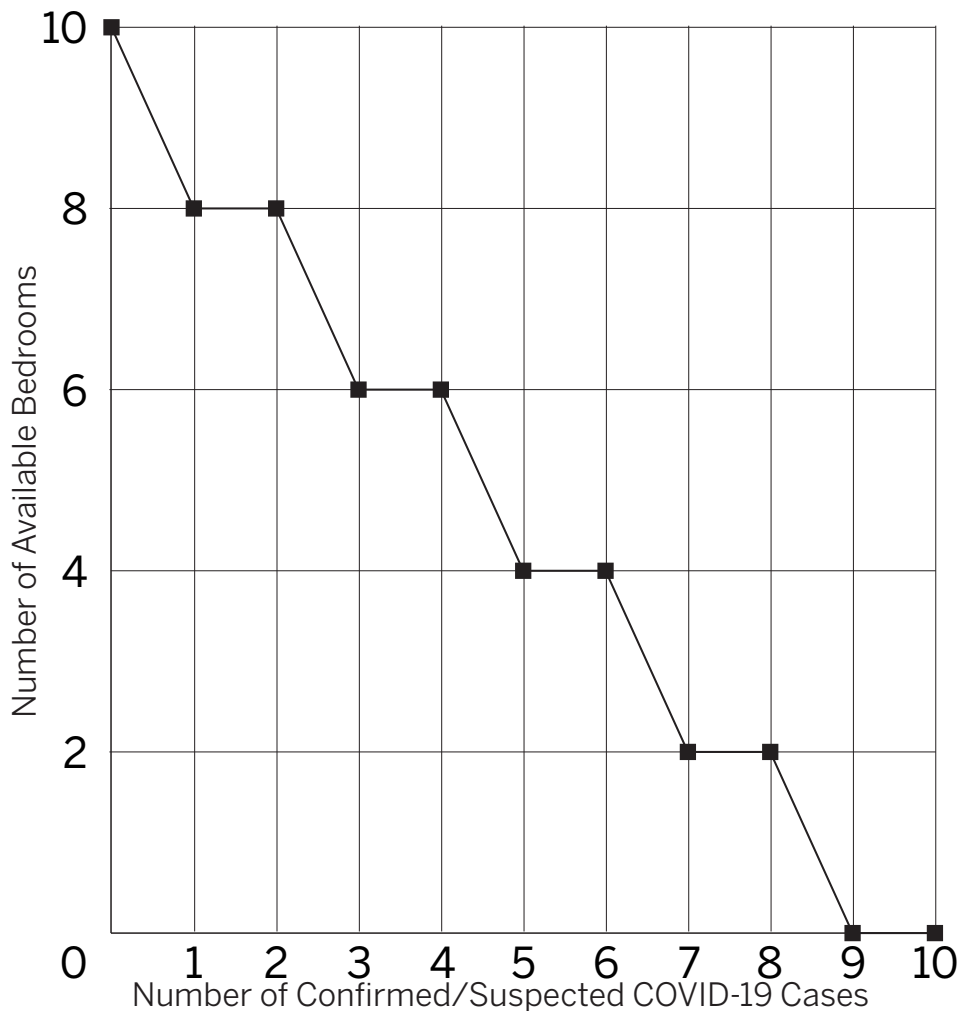


### Quarantine



Normal Operation Increased Cleaning Quarantined Space No Access No Access unless another B/R is avail.

### Available Bedrooms due to the Number of Confirmed/Suspected COVID-19 Cases in a Shelter with One (1) Bedroom to One (1) Bathroom

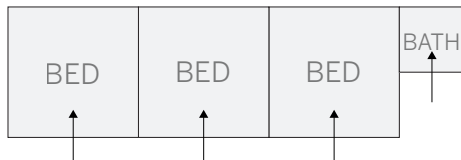


In a shelter with 10 bedrooms, 9 suspected/confirmed cases are required before all residential services are lost. This assumes that confirmed cases would be cohorted in adjoining bedrooms to maintain as many other open beds as possible.

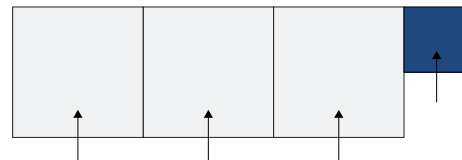
# Dorm-Style

Like the 2:1 bed to bath with the hallway entrance, this layout has more flexibility if bathroom assignments must be rearranged. However, because of the bigger ratio of rooms to bathrooms there is more risk in the shared bathroom. In the event of a quarantined bedroom, the shelter would have to provide a separate bathroom. As a whole, if an outbreak occurs the shelter would have to have one more bathroom than number of cases to avoid closure.

## Normal Operation



## Physical Distancing

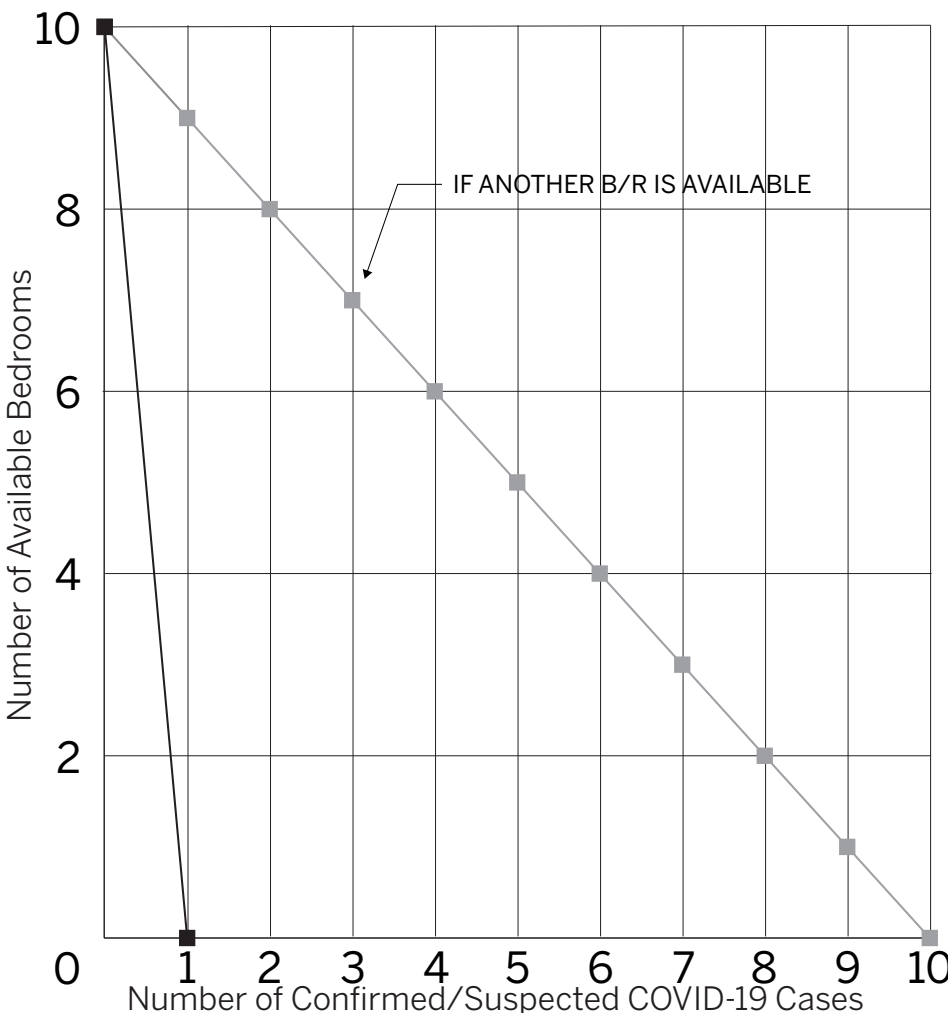


## Quarantine



Normal Operation
  Increased Cleaning
  Quarantined Space
  No Access
  No Access unless another B/R is avail.

## Available Bedrooms due to the Number of Confirmed/Suspected COVID-19 Cases in a Shelter with Dorm-Style Bedrooms

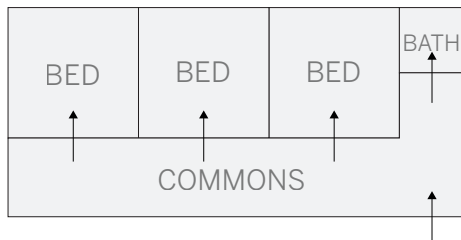


For dorm-style layouts, all residential services are lost for those not in the quarantine room, unless extra bathrooms are available.

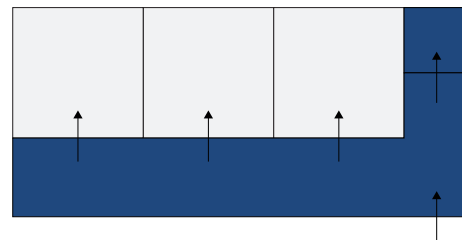
# Multi-Unit with a Shared Commons

Like the Dorm-Style layout, this example has a higher ratio of bedrooms to bathrooms. However, like the 2:1 bed to bath with a vestibule, this shared space is prohibitive in the case one of the bedrooms is quarantined.

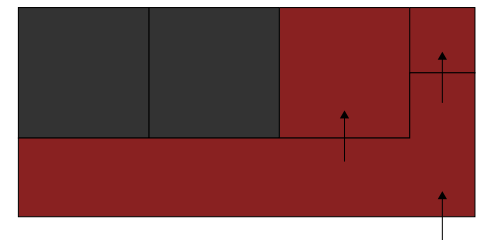
Normal Operation



Physical Distancing

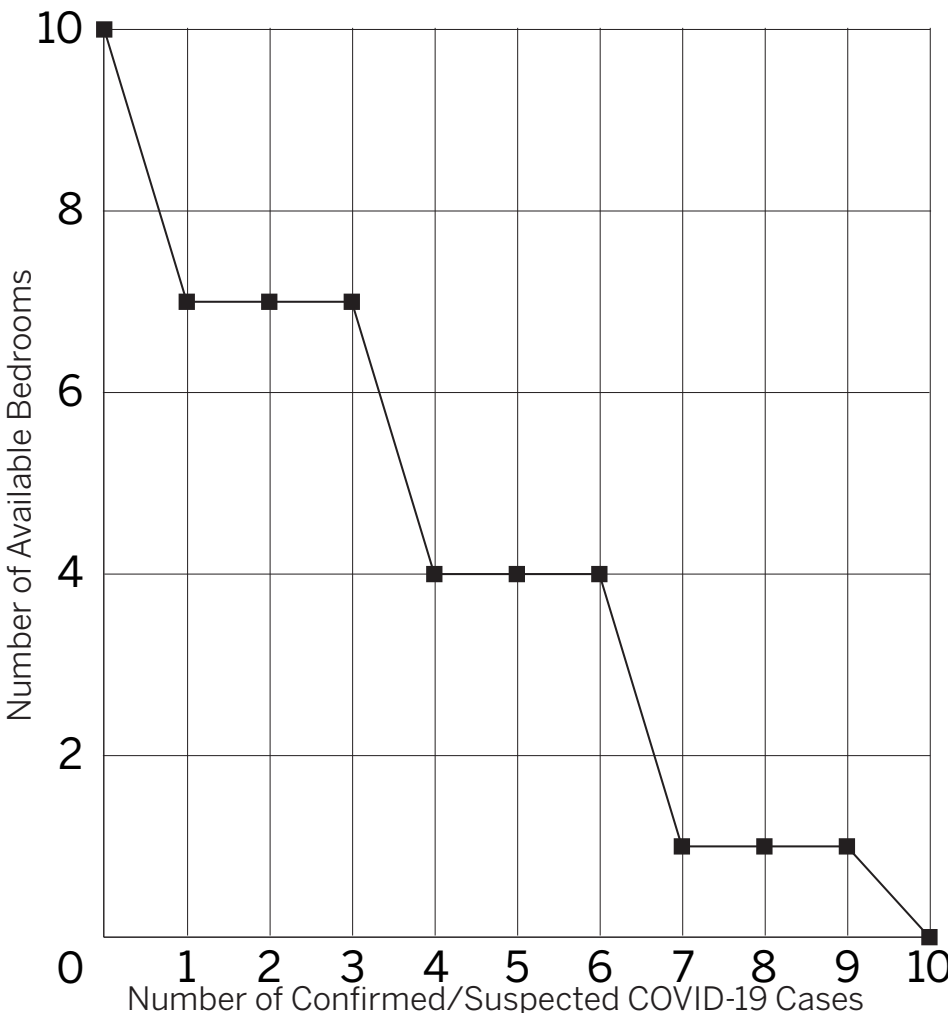


Quarantine



Normal Operation
  Increased Cleaning
  Quarantined Space
  No Access
  No Access unless another B/R is avail.

Available Bedrooms due to the Number of Confirmed/Suspected COVID-19 Cases in a Shelter with Multi-Unit, Shared Commons Bedrooms



In a shelter with 10 bedrooms, 10 suspected/confirmed cases are required before all residential services are lost. This assumes that confirmed cases would be cohorted in adjoining bedrooms to maintain as many other open beds as possible.



## Things to Keep in Mind:

1. The Ministry of Health recommends bathrooms be limited to one woman/family under pandemic protocols (see Appendix D). In some cases shelters opted instead to increase the cleaning of bathrooms to maximize the number of bedrooms that could remain open. The layouts above show both of these scenarios; “physical distancing” denoting increased cleaning, and “quarantine” showing the Ministry recommendation.
2. Most shelters had more than one bedroom type. The recommendations that apply to a shelter will depend on its specific layout(s).

# Spatial Recommendations

“The thing that could have the greatest impact on the shelter I’m working at, ability to continue to be creative and robust and responsive through a pandemic, would be having different kinds of space.”

- Focus Group Participant

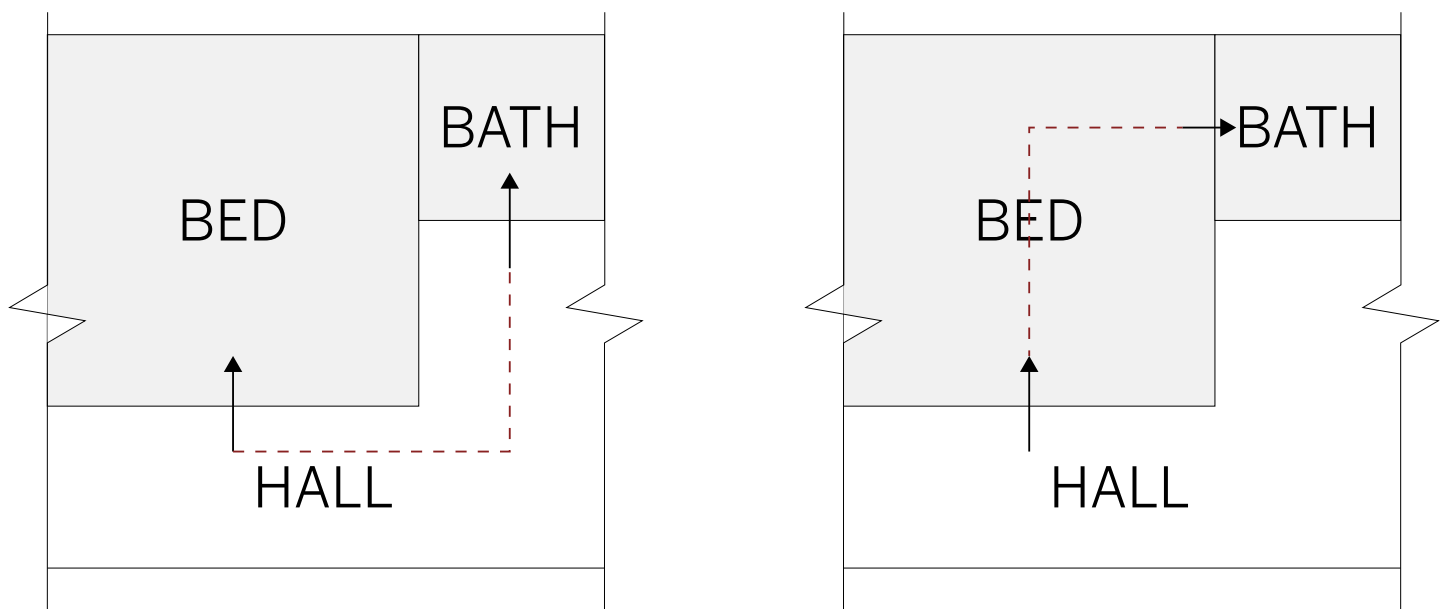
The following recommendations are split into three categories: new build, renovation, and immediate work arounds. They build on discussions with the GBV/VAW sector actors on how they adapted their spaces during COVID-19, as well as the analysis of their floor plans. Each category includes explanations of the impact that each of the recommendations has on increasing the flexibility of the shelter space for dealing with pandemics or similar situations.

## New Builds

This includes shelters that have yet to begin construction. The recommendations can be brought to the architects leading the project while it is still in the design phase.

### 1. Have at least one bedroom that has its own private bathroom.

In the case of an outbreak, this can act as a self-contained quarantine area. It limits the person's contact with things like hallways that are still in use by the rest of the staff/residents, thus mitigating the overall risk to the rest of the shelter (see Fig. 1).



**Figure 1.**

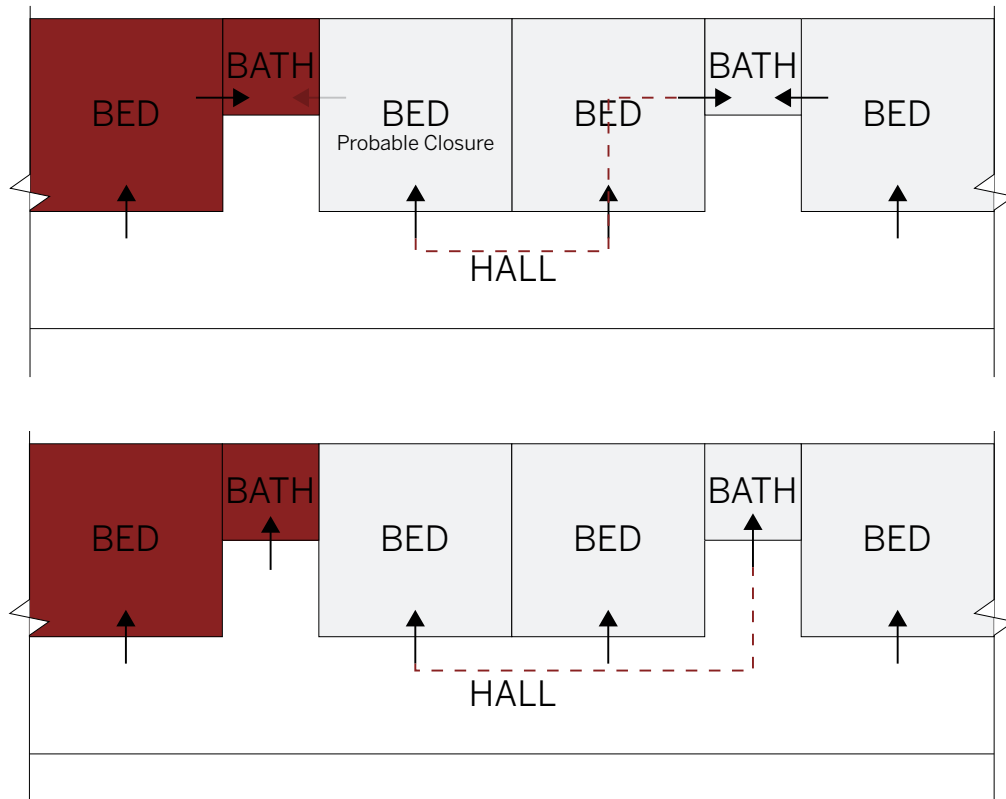
Bedroom/Bathroom entrance comparisons. One bathroom with access from the hall, and one with access through the bedroom. Only applicable when the bedroom to bathroom ratio is equal.

### 2. Create a commercial kitchen alongside the communal kitchen.

The pandemic has brought a shift from communal meals to those that are individually wrapped and handed out to the women in their rooms. By creating a commercial kitchen from the inception of a shelter, it builds in the role of “cook”, which was sometimes added to the workload of shelter staff, impacting their ability to provide counseling services.

3. Though the 1:1 bedroom to bathroom model creates the most flexibility, it can be prohibitively expensive. If the shelter predicts the use of shared washrooms with increased cleaning in the case of a pandemic, the next best model includes shared bathrooms that have access through the bedrooms (see pages 7 and 9).

By moving the bathroom entrances to the hallway (instead of from inside the bedroom), if an outbreak occurs past more than one case, bathroom assignments can easily be changed without having to go through other bedrooms or closing the other bedroom entirely, reducing contact between the women/families (see Fig. 2). This model only works if the shelter is choosing to increase cleaning, instead of reducing all bathroom occupancy to one person or family. Including one 1:1 model is still recommended in this circumstance.

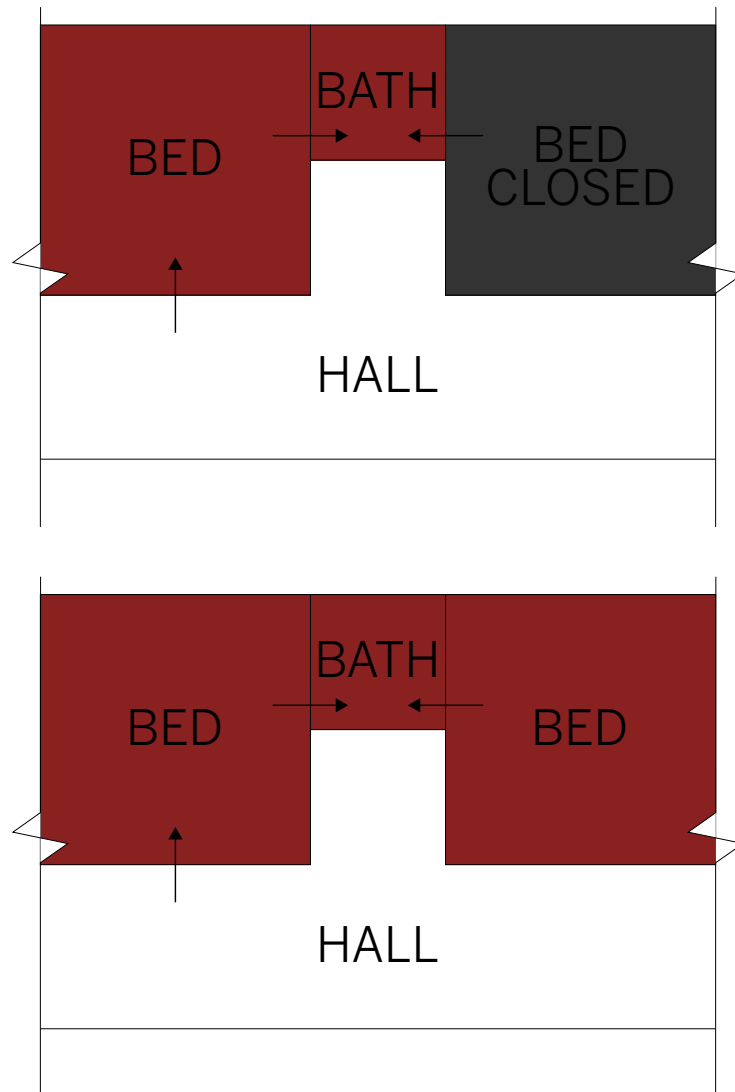


**Figure 2.**

Bathroom entrance comparisons for shared bathrooms between two bedroom units. In the first case, the bedroom sharing the bathroom with the quarantined bedroom would most likely need to close as the bathroom of the adjacent units require entrance through the bedrooms, increasing likelihood of viral spread.

**4. If the shelter predicts reducing bathroom occupancy to one person/family in the case of a pandemic, the 2:1 bedroom to bathroom model with interior entrance layout creates the most flexibility.**

If room closures occur, an entrance from the inside of the bedroom to the bathroom will effectively create the same layout as a 1:1 bedroom to bathroom layout. This layout may also be useful if there are larger families, as they can be isolated in both rooms with access to one another through the bathroom (see Fig. 3).



**Figure 3.**

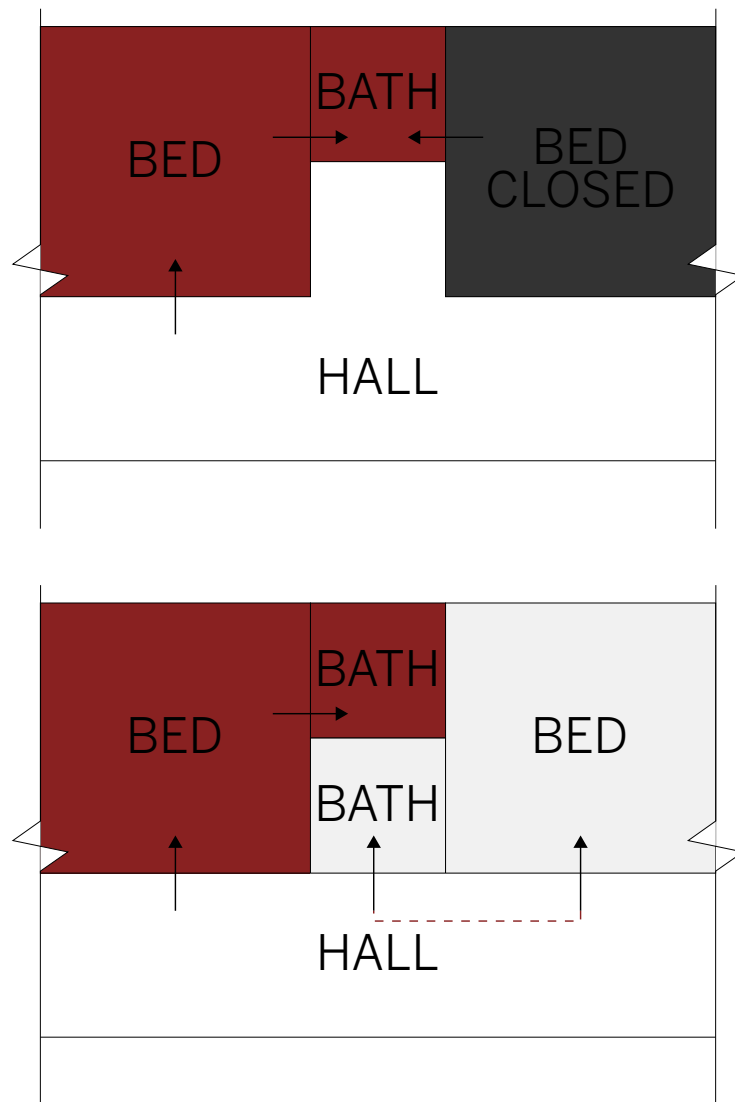
Shows the two options for the 2:1 bedroom to bathroom layout with interior options, if the shelter decides to reduce the bathroom occupancy down to one person/ family.

# Renovations

This includes shelters that are in the process of upgrading their existing infrastructure. The recommendations can be brought first to the Board for approval in the broader context of the renovation, and then to the project manager/architect.

## 1. Prioritize the addition of a bathroom with access from the hallway.

The addition of this bathroom will mean if a shared bathroom is under quarantine, the other bedrooms that were assigned to that bathroom can be reassigned to this additional bathroom, remaining open for use (see Fig. 4).



**Figure 4.**

Comparison of pre- and post-addition of an extra bathroom with an entrance from the hallway.

## 2. Create exterior spaces that can be used for outreach counselling sessions that require little to no interaction with the interior of the shelter space.

Building a patio or any kind of covered exterior seating in existing outdoor space can ensure outreach workers can resume face-to-face services more quickly, while reducing the risk to both workers and women. Limiting the exposure of those entering these spaces to the interior shelter space also ensures that there is less possible exposure for both parties (see Fig. 4).

# Immediate Work-Arounds

This includes low-cost, quick solutions for imminent situations.

1. **Create tape markings on floors, tables, or any other surface that requires physical distancing.**
2. **Rearrange the furniture to create visual cues for physical distancing.**
3. **If limiting one woman per bedroom is impossible, arrange beds “head to foot” or “foot to foot” to support physical distancing.**
4. **If reducing the number of available bedrooms for physical distancing reasons, consider combining adjoining rooms to create more space for women/families that have to spend the majority of the time in their rooms.**
5. **If necessary, consider turning offices left empty by work-from-home orders into temporary bedrooms. This should only be done if there are enough bathrooms to accommodate the extra women.**

# Glossary



**Accessible Square Footage (SQFT)**

The number of square feet that are available to women and children using shelter services depending on the state of the shelter (normal vs. pandemic protocols); excludes mechanical/service spaces.

**Bathroom (B/R)**

A water closet with a sink, toilet, and bath/shower (see Washroom).

**Barrier Free (BF)**

A space designed to accommodate people with physical mobility issues. Takes into account the accessibility needs of wheelchair users.

**Gender Inclusive Bathroom**

A bathroom that is not designated for a specific gender.

**Net Square Footage**

Total square footage of a space excluding walls, stairs, and mechanical airways. In other words, only the amount of space that can be physically walked on.

**Normal Operation**

The shelter space as it operates normally (not under pandemic protocols).

**Outbreak**

One or more suspected or confirmed cases of COVID-19 within the shelter space, as defined by the Ministry of Health.

**Physical Distancing**

The shelter space as it operates under pandemic and public health protocols without a suspected or confirmed COVID-19 case.

**Primary Spaces**

Bedrooms, washrooms, and bathrooms. Spaces that fill the basic needs of shelter for women using services, as defined by this project.

**Quarantine**

The shelter space as it operates with a suspected or confirmed COVID-19 case.

**Quarantine Room(s)**

The designated bedroom(s) and bathroom(s) that are set aside and prepared to house women/families with suspected or confirmed cases of COVID-19.

**Secondary Spaces**

Offices, community, and living spaces. Spaces that support the emotional and community needs of the women using GBV/VAW services, as defined by this project.

**Tertiary Spaces**

Circulation and storage. Any space that acts as a connector or storage for a primary or secondary space, as defined by this project.

**Washroom (W/R)**

A water closet with a sink and toilet only (see Bathroom).

# Appendix A

# Method

**Sample and Recruitment:** VAW/GBV services from across Ontario were contacted through the “Let’s Talk” listserv via targeted email by one of the partner shelter Executive Directors (EDs) on the project. The VAW/GBV services with access to this list included small, medium, and large shelters in urban, rural, and remote areas of the province. In the email they were asked to provide shelter floor plans in any form – if precise plans were unavailable, pictures of the shelter’s fire escape plan were recommended – and their current written pandemic protocols that described the operation of the shelter under COVID-19 guidelines.

**Procedures :** The data were collected between May and August of 2020 with shelters sending in their floor plans and written pandemic protocols. For floor plans submitted without protocols (n = 2) the Ontario Ministry of Health’s COVID 19 Guidance: Congregate Living for Vulnerable Populations was used as the default protocol for analysis of space impacts. ). Of those contacted through the “Let’s Talk” list, 15 floor plans from 13 VAW/GBV services were submitted from across Northern (n = 2), South Central (n = 1), Southwest (n = 6), Greater Toronto & Hamilton Area (GTHA; n = 3) , and Eastern Ontario (n = 1) including shelters of all sizes from urban, rural, and remote communities. These floor plans ranged from schematic hand drawn sketches to professional construction drawings. Because of the range of submission types, all of the floor plans were redrawn in CAD software; if no scale was provided on the original drawings, door openings were used as a reference point and scaled to the construction standard of three feet.

Concurrently, the written pandemic protocols were analyzed for any mention of procedures related to space use. These procedures included things like room closures, changes in room functions, and occupancy limits. Using language from the protocols three broad classifications of operation, normal operation, physical distancing, and quarantine, were used to explore the changes to space under each scenario.

The spatial changes described in each pandemic protocol were then mapped onto their respective floor plans to determine how much space was lost under each mode of operation. To determine the space lost, the net area (exclusive of walls and vertical circulation) of the limited access spaces was divided by the total net area of the shelter to create a percentage of space lost for each stage of operation. During normal operation limited access spaces included mechanical and electrical rooms. During the two stages of COVID-19 operation, limited access spaces included bathrooms, bedrooms, offices, kitchens, dining rooms, and other community areas. A percentage was used instead of a firm square-footage because of the variability of type of floor plan submitted, as square-footage was not always precise due to the schematic nature of some of the submitted drawings.

To not only understand how much, but what kinds of spaces were lost to the new pandemic protocols, three categories of shelter space were created with the input of the shelter EDs to confirm the efficacy of their description of shelter space use. These categories were Primary Spaces (including bedrooms, bathrooms, washrooms, and laundry rooms), Secondary Spaces (including community rooms like kitchens, dining and living rooms, as well as staff offices and counselling rooms), and Tertiary Spaces (circulation and storage). The percentage of space loss was once again calculated for normal operation, physical distancing, and quarantine scenarios, this time breaking them down further to analyze how much of each of the three spatial types were lost at each stage.

Sheets which included drawings and the percentage breakdown of space loss were then created using illustration and layout software and sent to each shelter to confirm the accuracy of the information. In some cases, shelters had made spatial changes since the original submission of the protocols which were used to update their sheets and provide a more accurate view of their space.

The Handbook represents an aggregation of the findings from these 15 VAW/GBV services and their space changes.

# Appendix B

# One-Step Pandemic Protocol

Example shelter-submitted protocol.

AS OF MARCH 23, 2020 due to COVID 19 – no new admittance to shelter without following procedures below.

AS OF April 8, 2020 due to COVID 19 – (This will be updated as the situation evolves)

- there will be no visitors on site (excluding essential personnel)
- no groups or outreach appointments on site
- no outreach appointments in the community or community meetings
- no gatherings
- no childcare
- All Outreach/Children's Centre staff/Cook/Housing/Management staff will be working from home conducting any counselling via telephone or alternative electronic methods (zoom, facetime, email, facebook, texting, etc.)
- no travel

Active Screening during COVID 19 Pandemic:

All people including staff must be screened each day upon arrival or at a daily check in. All results are to be captured and recorded by the front line staff on duty:

Front line staff to mask and glove up and must keep 6 ft of distance do the following:

- 1) Have the woman take her and if there are children, temperature in your presence so you can record. If this is a reading of 37.8 degrees C or higher this is an indicator of covid-19 and she has failed our screening OR
- 2) Do you have a new or worsening symptoms (e.g., cough, any difficulty breathing or any shortness of breath, sore throat, runny nose or sneezing, nasal congestion, difficulty swallowing, new olfactory or taste disorder(s), nausea/vomiting, diarrhea, abdominal pain) OR
- 3) Clinical or radiological evidence of pneumonia

1. Have you travelled outside Canada in the last 14 days?
2. Have you travelled outside of Northwestern Ontario in the last 14 days?
3. Have you been in contact with anyone who has travelled outside Canada?
4. Have you been in contact with anyone who has travelled outside Northwestern Ontario?
5. Have you been in contact with anyone who has been ill in the last 14 days or has a diagnosis of COVID 19?

A. Anyone who answers yes on the crisis call will not be admitted to shelter and if someone in the shelter answers yes they are given gloves and a mask and sent to their room or if staff, sent home.

## POLICY

THE SHELTER shall have an Emergency Plan in place to ensure the safety of residents and staff. The Emergency Plan is designed for incidents such as a pandemic or serious outbreak of contagious illness.

This plan shall be implemented by staff as soon as an emergency occurs or is expected which is considered to be of such magnitude as to warrant its use.

### 1. PROCEDURES

1.1 In the event of an outbreak of serious infectious illness, a management group will be established to include: Executive Director, Shelter Manager, Finance Manager, Maintenance Worker and the Chair of the Board.

1.2 The Management group will:

1.2.1 maintain updated daily information on staff availability

1.2.2 managing the deployment of staff to support key service delivery e.g., front line, outreach, supplies, drugs, fuel, etc.

1.2.3 provision of advice and guidance to staff on all matters

1.2.4 monitoring the availability and distribution of key supplies and support services

1.2.5 liaison with other facilities regarding transfer of women and children

1.2.6 convey accurate, timely and consistent advice to the public (including media), Local Health Care Unit, staff, women and Board of Directors and MCCSS Supervisor. This role is the total responsibility of the Executive Director.

1.3 Limiting the Spread of Infection: the staff, women and children will use the following strategies:

### 2. STRATEGIES: FOR THE SHELTER DURING A PANDEMIC IDENTIFIED IN OUR COMMUNITY

#### 2.1 PREVENTION:

2.1.1 Hand sanitizer stations are located in all high-traffic areas and women, children and staff reminded to use frequently

2.1.2 Soap dispensers are installed in all washrooms and frontline to monitor (during room checks) to ensure topped up regularly

2.1.3 Frontline staff to sanitize high traffic surfaces and frequently-touched objects (door knobs, etc.) throughout a 24 hour period

2.1.4 Reducing activities that require physical contact between workers and/or members of the public, if possible; and

- 2.1.5 Reminder that employees need to wash their hands frequently; practice social distancing 2 m apart; and stay home from work if they exhibit symptoms of COVID-19.

### **3. STRATEGIES: FOR WOMEN AND CHILDREN IN SHELTER WHO ARE NOT SICK DURING A PANDEMIC OR SIMILAR**

•

#### **3.1 PREVENTION:**

- 3.1.1 All women and children must be told and be sure to understand, they must think of themselves as having the virus and being asymptomatic and with this understanding conduct themselves and their families to make sure they are not spreading the virus to others by doing the following:
  - 3.1.1.1 women and children can remain in their room as much as possible, avoiding common areas.
  - 3.1.1.2 when women and children leave their room they can use hand sanitizer regularly and/or wash their hands regularly and do not touch their face.
  - 3.1.1.3 Take steps to reduce the potential for spread of infection through good personal hygiene (change your toothbrush if you have been ill, brush your teeth, ensure your clothes, towels and bedding are regularly washed, etc.)
  - 3.1.1.4 practice social distancing – 2m / 6ft.
  - 3.1.1.5 do not share anything that comes into contact with your mucous membranes (eyes, nose, and mouth). This includes items such as food, drink, drinking containers, lip balm, lipsticks, pens, pencils, emery boards, etc. Wash your hands before you touch any surfaces.
  - 3.1.1.6 Ensure personal items are not in your bathroom – keep in your bedroom
  - 3.1.1.7 Sanitize and clean your bathroom daily. Use disinfecting wipes or paper towel and spray cleaner after using the bathroom (you will need to do this after your children use the bathroom as well). DO NOT put these wipes or paper towel in the toilet.
  - 3.1.1.8 Please note there will be no access to the kitchen.
  - 3.1.1.9 Do not attend social events or spend any time in common areas.
  - 3.1.1.10 If you are instructed by staff to not leave the property, do not leave the property or you will have discharged yourself and will not be readmitted.
  - 3.1.1.11 Women are to identify to staff as to whether they and their children have been vaccinated and this information will be put in the staff notes, their files and in the file with the Maintenance Worker.



#### **4. POSITIVE SCREENING: WOMEN AND CHILDREN - WHAT TO DO:**

4.1 If a woman or her children reports or shows symptoms of COVID-19 or they have been exposed to someone who has COVID-19, they should be isolated immediately. (see #8 below). Direct woman to THE HEALTH UNIT website to complete the following screening before calling. <https://www.THEHEALTHUNIT.com/coronavirus>. Staff could take the woman through this screening if needed while using baby monitor. Do not go into a hospital or clinic to get a COVID-19 test unless you are asked to by a health care provider. If medical advice is required for any woman or child, call their primary care provider or Telehealth Ontario at 1-866-797-0000 and tell them that the person lives in a woman's shelter. If at any time the person's condition worsens call 911 immediately.

4.1.1 Women are required to tell staff immediately, mask and glove up (women and children), stay in their room and not access any common areas. See staff for assistance. (detailed procedures below in Section 8) If women and children get information they are sick they are to call the shelter prior to returning so that decisions can be made to keep all people protected. This may include moving this family to a motel.

4.1.2 Women and children who identify as being infected will be quarantined to their rooms for a minimum of 14 days. Should a woman, who has identified as being infected, decide to leave the shelter she will not be readmitted and if required the Health Unit will be informed she has left.

4.1.3 Frontline duties if infection in house detailed below.

4.1.4 Should we have more than one person that is unwell on site, The Health Unit will be informed as this may indicate an outbreak in the shelter.

#### **5. STRATEGIES: FOR STAFF**

##### **5.1 PREVENTION**

5.1.1 It is your responsibility and right to enforce / practice social distancing – 2m / 6ft

5.1.2 Use hand sanitizer regularly and/or wash your hands regularly, take steps to reduce the potential for spread of infection through good personal hygiene (role modelling for others). Keep your office area clean by using the disinfecting wipes provided, etc.

5.1.3 Staff who have symptoms that may be from COVID-19 (refer to diagram at end) or have been exposed to someone with suspected or confirmed COVID-19 are required to self-isolate and must not come to work. If after discussion with your supervisor, the decision is made for you to attend work, please wear a face mask, etc. Staff must report their symptoms to their supervisor/manager and follow the self assessment at <https://www.THEHEALTHUNIT.com/coronavirus> to determine next steps.

5.1.4 The Secretary/Maintenance Worker will be maintaining a list of everyone (women, children, staff, etc.) in the shelter as to whether they have had the flu shot, and when they are ill what does the illness look like. Everyone is asked to be cooperative in giving this information which will only be shared with the management group with the intent to be aware of the spread of infection, etc.

5.1.5 During the COVID 19 pandemic, the childcare room is closed.

5.1.5.1 Childcare room is to be sanitized everyday at the beginning of the day by the childcare worker on shift. All trips outside the shelter are to be restricted. When we have no children in the shelter this childcare room is to be locked to keep it sanitized.

5.1.6 Should we have more than one person that is unwell on site; the Health Unit will be informed.

## **6. POSITIVE SCREENING – STAFF - WHAT TO DO:**

6.1 Staff who become unwell in the shelter should call their manager immediately and separate themselves from others. They need to mask and glove up immediately. Once arrangements made for coverage, they should go home (avoiding public transit) and follow the self assessment at <https://www.THEHEALTHUNIT.com/coronavirus> to determine next steps.

6.1.1 The Symptomatic staff should advise health care providers at the Assessment Centre that they work with a vulnerable population in a shelter setting.

### **6.2 STAFF RETURNING TO WORK:**

6.2.1 If COVID-19 is suspected or diagnosed in staff, return to work should be determined in consultation with their health care provider and the local public health unit. The staff must notify their supervisor prior to return to work and provide a Dr. Note saying they may return to work with this population. See Guidance for Occupational Health and Safety for COVID-19 on the Ministry of Health COVID-19 website.

6.2.2 Staff should check for signs of illness compatible with COVID-19 before each shift using the self assessment tool provided by the Ministry of Health. Individuals should follow the directions provided by the self-assessment tool. This may impact staffing levels but is a precaution to prevent spread of illness in the community.

6.2.3 Individuals who were positive for COVID-19 and are now free of symptoms for 14 days after the onset of the symptoms can return to work. Individuals who are critical to operations and are symptom free can return to “work self-isolation”. An explanation of the requirements of work self-isolation is available on the Health Care Resources section of Public Health Ontario’s website. For up to date information, consult with the local public health unit if there are questions about return to work for staff, including testing and clearance guidelines.

## **7. CRISIS LINE / WALK IN / VISITORS / MAINTENANCE**

### **7.1 PREVENTION**

7.1.1 No walk ins will be taken in person during a pandemic. Women are to be referred to a counsellor by phone.

7.1.2 No visitors during a pandemic and maintenance would have to be essential to be allowed into the shelter and pass the screening process.

### 7.1.2.1 On the Crisis Line,

Ask women the screening questions:

1. Do you have a new or worsening cough?
2. Do you have any difficulty breathing?
3. Have you travelled outside Canada in the last 14 days?
4. Have you travelled outside of Northwestern Ontario in the last 14 days?
5. Have you been in contact with anyone who has travelled outside Canada?
6. Have you been in contact with anyone who has travelled outside Northwestern Ontario?
7. Have you been in contact with anyone who has been ill in the last 14 days or has a diagnosis of COVID 19?

Ask if they or their children have flu symptoms: (go through each symptom)

1. fever
2. cough
3. difficulty breathing
4. shortness of breath
5. have been diagnosed with COVID 19

Also ask if they have been vaccinated and be sure to add the information to their intake and on the IMS.

Anyone who answers yes on the crisis call will not be admitted to shelter

7.1.3 During a pandemic only healthy high risk women will be admitted to THE SHELTER. Women who are not healthy and cannot pass the screening questions and tests will not be admitted. These women and other lower risk women may be rerouted to motels as per policy 1.10.

7.1.4 During a pandemic, do a risk assessment on them, screen them, call your back up (who will check with the Shelter Manager) and determine if the risk brings them into shelter or to a motel. This would occur where the risk of re-assault for physical violence is life threatening to either the woman or child. The woman must be advised that she/family are required to do the 14 day quarantine and explain so that she understands what this means (details below). If she can't agree to this, then she must not be brought into the shelter.

7.1.5 If she has children, there must be a verified phone number (staff and the woman to call it) for emergency childcare should the need arise.

7.1.6 When the determination of high risk is made, women and children presenting with flu symptoms or diagnosed flu can be put in a motel if this is a safe option for them.

7.1.7 If the motel is not a safe option, staff are to call the Executive Director, the Shelter Manager or the Finance Manager and they will collectively determine action to be taken.

## **8. OUTREACH / 50+ / CHILDCARE / GROUPS**

### **8.1 PREVENTION**

8.1.1 Ask women all the screening questions: if they or their children have flu symptoms or have been diagnosed with the COVID19 or travelled to or in contact with someone who has travelled outside NWO. Also ask if they have been vaccinated and be sure to add the information to their intake and on the IMS

8.1.2 If they confirm they have symptoms or have been diagnosed, please do their outreach via the phone or facetime if available. Do not bring women suspected or confirmed of COVID19 into the shelter for services.

8.1.3 All group activities must have the MPR sanitized before and after group. If a woman comes to group and is ill, send her home in a cab. Sick children are not to receive childcare. Note there will be no groups during a Pandemic.

## **9. HIGH RISK WOMAN / FAMILY BROUGHT INTO SHELTER WITH NO SYMPTOMS**

### **9.1 PREVENTION**

9.1.1 Continuing operations during the pandemic when a high risk woman and her children have been admitted to the shelter due to high risk of lethality or re assault

9.1.2 Anyone admitted to the shelter once most families have been moved to motels as per policy 1.10 will be quarantined for 14 days. Because they are high risk, this means going outside is not an option. Women must be told and agree to these terms on the Crisis Line. The first family will be isolated to 1A and 1B. This means:

9.1.2.1 They must stay in their rooms and not leave the room

9.1.2.2 Staff will be masked and gloved up to admit the woman and family. Family can be masked and gloved up as well to be taken to their room. Please keep 6 ft distance to the best of your ability and ensure there is little touching of any surfaces on the way to their room.

9.1.2.3 Staff will have a supply of masks and gloves in the woman's room, snack food, diapers, wipes, etc. Plan to have the room ready with all supplies before they arrive.

9.1.2.4 Give family one of the baby monitors and decide how you will communicate with her either using the baby monitor or if she has a phone. Gather this info on the Crisis Line and put it in the staff notes and Crisis call.

9.1.2.4.1 Staff will check in with the women/ children three (3) times per shift and document.

9.1.2.5 Harm Reduction - Consideration will be given to women when they call the crisis call line as to their needs under our harm reduction policy. This may include offering clean needles and pipes from our supply. Asking general questions around their need/use. Due to their high risk and not being able to go outside, our policies may have to be temporarily amended due to the situation after

consultation with the Shelter Manager.

9.1.2.6 Women and children who are high risk cannot be let outside due to safety concerns. However, given the impact of being isolated for long periods, management may decide to let the family into the family room to have some movement if they are still not showing symptoms. This will be decided during the course of their stay.

9.1.2.7 Food will be delivered three times a day by Front Line staff and the assistance of the cook. Put prepared food and plastic and/or paper cutlery, cups, plates etc. on one of our carts. Bring cart down to the room and leave it at the outside door. Notify the woman by phone or whatever means has been decided. Staff is to be gloved and masked in doing the delivery and the pickup and are to stay masked and gloved while they dispose of all garbage from the meal into a garbage bag and put inside back door of the MPR (if outside birds can get into it and rip it apart) to be taken out at end of shift to the BFI. Then with gloves still on disinfect the cart for the next meal. Whoever is moving the garbage to the BFI is to be gloved.

9.1.2.8 Women will keep their meds with them and if they have any for their children. We will request these be put in the safe in their rooms. Women can also use their fridges to store meds if needed as well as food.

9.1.2.9 Laundry will need to be considered for people quarantined. We can provide laundry soap to the family if they want to wash a few things just by hand. Thought will be given to allowing the family to mask and glove up providing they are healthy (pass the screening) and access the laundry room. Staff would have to disinfect the laundry room after as well as the corridors used to get to the laundry room.

9.1.2.10 If after 14 days everyone in quarantine pass the screening they can be removed from isolation to a new room or Motel depending on risk. While they have more leeway, they are still required to follow #3 above.

9.1.2.11 Once moved from the isolation/quarantine room, the room will be cleaned following step 9 to prepare in case another high risk call comes in.

9.1.2.12 Should the family develop symptoms during the quarantine period, continue using all your PPE and management needs to be notified immediately to decide if/how service can continue.

## **10. WOMAN/FAMILY IN SHELTER THAT ARE SICK WITH SUSPECTED OR CONFIRMED COVID-19:**

10.1 If the sick woman or child has symptoms that may be COVID-19 and the shelter setting staff have health questions, call the persons doctor/NP (if permitted) or Telehealth Ontario (1-866-797-0000) and tell them that the person lives in a women's shelter. Follow 4.1.

10.2 If staff are advised to transport the woman or child to an Assessment Centre, arrange private transportation (no public transit is allowed) and have the woman/child wear a mask, sit alone in the backseat and open the car windows if possible. The driver of the vehicle should wear a mask.

10.3 A sick person in all women's shelters should advise health care providers at the Assessment Centre that they are in a women's shelter.

### 10.3.1 DIAGNOSED POSITIVE RESULTS:

10.3.1.1 An unwell resident may recover at the shelter or other arrangements will be made by management

10.3.1.2 Residents who have mild to moderate symptoms may recover at home in the shelter. They must remain in their room, receive meals in their room and should not share a bathroom with others. (follow #8 above) They should be monitored several times a day to ensure that their symptoms do not worsen.

10.3.1.3 If the unwell person gets worse and needs to go to the hospital because of severe symptoms (e.g., severe difficulty breathing, severe chest pain, very hard time waking up, confusion, loss of consciousness), call 911 and inform them that the person is suspected of having COVID-19 so that the hospital can be notified and the paramedics can take the necessary precautions.

10.3.1.4 Staff should contact their local public health unit to report a staff member, or person within the shelter is suspected to have COVID-19. The local public health unit will provide specific advice on what control measures should be implemented to prevent further spread in the shelter.

## 11. CARE AND INFECTIOUS CONTROL:

11.1 To assist with the extra cleaning that would be required:

11.1.1 In the unlikely event that we have an ill/unwell woman or family on-site, Management will supply a second set of hands or hire a cleaning service to assist with the increased cleaning that will need to occur.

11.1.1.1 Plan to clean and disinfect the rooms occupied by unwell residents frequently, twice per day and when visibly dirty. The lid of the toilet should be down before flushing to prevent contamination of the environment. Disposable contaminated items including used PPE should be placed in a closed bag and placed with other household waste.

11.1.1.2 Laundry can be done regularly with warm water (60-90°C), and thoroughly dry the laundry. Wear gloves, a mask, and gown when handling the dirty laundry from unwell residents and keep it away from the body. If the laundry hamper/container comes in contact with contaminated laundry, disinfect it.

11.2 Droplet and Contact Precautions include using Personal Protective Equipment (PPE):

11.2.1 procedure masks provide a physical barrier that helps prevent the transmission of the virus by blocking respiratory droplets propelled by coughing, sneezing and talking and should be used when in close contact (less than 2metres) with the ill person;

11.2.2 disposable single use gloves should be worn when in direct contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids. If disposable gloves are not available, reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use with a disinfectant;

11.2.3 isolation gown when skin or clothing may become contaminated. Reusable gowns may be used; however, they must be laundered with soap and warm water (60-90°C) after each use;

11.2.4 eye protection such as goggles or a face shield for care or activities likely to generate splashes or sprays of body fluids.

11.2.5 Before using PPE, staff should be familiar with how to safely put it on and take it off. Detailed instructions on how to use PPE are available on Public Health Ontario's website:

11.2.5.1 <https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/health-care-resources>

11.2.5.2 OR – refer to Appendix A of this policy –

11.2.5.3 Tasks that do not involve close contact and direct care with the person with suspected or confirmed COVID-19 do not require PPE.

12. ENVIRONMENTAL CLEANING: Pandemic housekeeping/cleaning routines are to be maintained as noted above and detailed here.

12.1 Increase environmental cleaning and disinfection especially in high use / common areas and for high touch surfaces (e.g. doorknobs, light switches, phones). Clean and disinfect frequently touched surfaces at least twice per day and when visibly dirty. Increase environmental disinfection routines, concentrating on high contact areas such as toilet handles, faucets, doors, etc.

12.2 Continue normal dishwashing practices. Do not share dishes, drinking glasses, cups or utensils.

12.3 Continue normal laundry practices. Gloves may be used to handle laundry as an extra precaution.

12.4 Be careful when touching waste. All waste can go into regular garbage bins. When emptying, be careful not to touch any used tissues with your hands.

## **13. SHIFT CHANGE DURING PANDEMIC**

### **13.1 PREVENTION:**

13.1.1 Shift change will be using 'ghost shift changes' with no overlap in shifts to limit exposure (do all your notes electronically). Just before shift end, put the garbage outside the MPR door. Staff finishing their shift will have all their things at the MPR door 15 minutes before shift ends including a clean pair of gloves. When the next staff on shift rings the bell, current staff will unlock the front door and push it open, then make their way towards the MPR door to exit the building. The other staff will walk in and lock the door behind her. Current staff to take garbage to BFI and safely discard gloves at this time into the BFI bin (refer to Appendix A for safe removal if needed). Apply hand sanitizer in your vehicle if desired. Come back and ring front bell only if you soiled your hands and need to wash or if you were unable to take your belongings with you during the garbage run. Leave through the MPR door, ensuring it is secured on exit.



# Appendix C



# Multi-Step Pandemic Protocol

Example shelter-submitted protocol.

## Level One – Increased Awareness

All sites, programs and services are running

Universal precautions with increased handwashing and sanitization

Gloves, hand sanitizer and surface cleaners at all sites

Hand sanitizer for anyone working in community

Increase surface cleaning by everyone

Additional screening for intake, visitors, service providers, clients etc. – see manager/director for forms

Self-screening questionnaire for staff/volunteers: including are you sick, have you traveled, have you attended large events?

If you are sick, don't come to work. If you've been around someone who is sick don't come to work.

Signage on doors – already up

Recommendation for self-precaution i.e. attending events, workshops, large gatherings etc.

Monitoring Community Partner Communications for updates and direction

Training with residents and staff on how to proper hand washing and sanitization. Here's a video that demonstrates proper handwashing.

Pandemic team meets regularly and looks at level 2 for planning

## Level 2 - Heightened Procedural Precautions – (Social Distancing i.e. Community Closures)

“Social distancing” is a term that epidemiologists are using to refer to a conscious effort to reduce close contact between people and hopefully stymie community transmission of the virus. At minimal, it means maintaining at least 1 meter (3 feet) distance between yourself and anyone who is coughing or sneezing. When someone coughs or sneezes they spray small liquid droplets from their nose or mouth which may contain virus. It also looks to limit large social gathering.

All of the infection control measures in Level 1 continue.

- Replenish gloves, hand sanitizer and surface cleaners at all sites.
- Potential ordering of 3month supply of essential items including cleaning supplies.
- Cooks inventory and start planning – do not donate to other community programs.
- Exercise caution in putting out communal foods (ie popcorn/chips etc.).
- Meetings - online when possible, Zoom, teleconference.
- Communicate with city on a regular basis – re: emergency preparedness.
- Optional work remote for those with access if necessary i.e. high-risk employees, check in with manager/director if you require remote work.
- If you are sick don't come to work, if you've been around someone who is sick don't come to work.
- Staff don't attend or host meetings over 25 ppl i.e. staff meetings, community meetings, PD. Staff meeting is cancelled for face to face meeting. More details to come.
- Start discussing emergency back/up plans with residents and all clients if they cannot attend in person meetings.
- Close donations.

- Temporarily pause shelter intakes, start shifting residents to individual rooms with priority for Pandemic high-risk health vulnerabilities. Intake may resume after the above measures have been met and provided there is space. If you have questions about priority for Pandemic high-risk, refer to your manager/director/on call.
- Avoid site to site travel if possible.
- Suspend external groups.
- Suspend community groups.
- Prepare laminated instructions for changing server tapes.
- Prepare laminated checklists for daily cleaning and the other items. Being developed now.
- Volunteer training suspended.
- Vacation time/approval on hold unless already approved.
- Identify those with travel, track employees, being done by Leadership Team right now. Pandemic Team regularly and plans for level 3.

#### Infection control measures

Signs every sink.

Soap and water paper towels at all sinks. Avoid use of hand dryers.

### **Level 3 – Indication from Local Public Health Agency that there is community spread locally**

Continue with restrictions in Level 1 and 2

- In conversation with your manager, dependant on your role and the needs of the needs of the agency staff are encouraged to work from home.
- Job functions may be redirected to support agency.
- No volunteers.
- Continue to move women /families to separate rooms.
- No sharing of bathrooms with shower.
- Outreach services – telephone only.
- No outings, i.e. childcare to museums etc.
- Petty cash increase on hand.
- Move petty cash, gift cards, taxi vouchers, bus tickets, any essential files and cheques to x. Pre-sign cheques and x will take the stamp.
- Cancel courier.
- Crisis and support line to remote answered by staff.
- No site to site travel unless approved by a Manager or a member of the Pandemic Team.
- Press release to community.
- Meals continue with portioning as long as we have cooks and inventory allows.

Pandemic Team meets regularly and plans for level 4 (on-line).

### **Level 4 – Confirmed Case in resident/client/tenant or staff**

Pandemic Team to determine if these some restrictions are localized to one site or agency wide

Continue with restrictions in Level 1, 2. 3

- Staff are designated at sites – no travel between location.
- Increase in disinfection cleaning (7 days of week).
- Isolation of resident.
- Invoke skeletal staff for shelter, if necessary.
- No cook – meals will be individually portioned while supplies last.
- Close communal spaces.

- Close intake at shelter.
- Look at alternative places for those that are vulnerable due to Pandemic.
- Any services provided via video conference or telephone will continue provided staff are available.

Pandemic Team meets regularly and plans for Level 5.

**Level 5 – Close Shelter: Lack of resources (staff, food, PPE – soap, masks, gloves, cleaning surface disinfectant)**

Pandemic Team to determine if both shelters or just one close

Helpline continues to operate 24/7 provided staff are able.

All outreach continues provided staff are able phone/video.

Pandemic team meets regularly and plans for reopening.

# Appendix D

## 1. Hand Hygiene

Proper hand hygiene refers to hand washing, or hand sanitizing to maintain clean hands and fingernails. Hand hygiene should be performed frequently with liquid soap and water or ABHR for a minimum of 15 seconds. Hand washing is preferred when hands are visibly soiled.

Residents should be reminded to perform hand hygiene frequently throughout the day, and where required, assistance should be provided to residents who may not be able to perform it on their own.

## 2. Physical Distancing

Physical distancing refers to keeping a distance (a minimum of 2 metres or 6 feet) from other individuals and limiting activities outside the congregate living setting.

Physical distancing may help reduce the transmission of COVID-19 by limiting the number of people that individuals come into close enough contact with to transmit the illness.

Strict physical distancing should be practiced to help protect all residents, including those with increased risk of severe outcomes from COVID-19 (e.g., older adults, individuals with underlying medical conditions and, those who are immunocompromised due to medical conditions or medications).

- Residents should be provided with the necessary means to physically distance without creating undue social isolation.
- Activities provided in the congregate living setting should be altered to optimize and maintain physical distancing. This may include:
  - Postponing or cancelling face-to-face activities.
  - Staggering meals and/or break times and creating schedules for common areas or shared bathroom facilities.
  - Ensuring there is adequate spacing between residents/staff while eating (at least 2 metres apart).
  - Enabling people to access phones, computers, internet, television, video games or other activities in a manner that keeps people at least 2 metres apart and promoting hand hygiene before and after use.
  - Clean and disinfect any shared equipment after use with a product that is compatible with the equipment.

Ministry of Health

# COVID-19 Guidance: Congregate Living for Vulnerable Populations

Version 1 – May 28, 2020

This guidance document provides basic information and is not intended to take the place of medical advice, diagnosis or treatment, legal advice or requirements.

In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

- Please check the Ministry of Health (MOH) [COVID-19 website](#) regularly for updates to this document, list of symptoms, other guidance documents (e.g., for Long-Term Care Homes and Retirement Homes), Directives and other information (e.g., mental health resources). Health care workers should refer to these documents for specific guidance and direction with respect to health and safety and providing patient care within these settings.
- Please check the [Directives, Memorandums and Other Resources](#) page regularly for the most up to date directives as well as other resources including the provincial COVID-19 testing strategy.
- Some congregate living settings may also be subject to emergency orders made under the [Emergency Management and Civil Protection Act](#), including staff mobility. All settings subject to emergency orders must follow the requirements of these orders.
  - Additional information regarding emergency orders can be found [here](#).

This document is intended to assist with minimizing COVID-19 transmissions from individuals working or residing in congregate living settings and to help prevent, detect and manage individual cases and outbreaks of COVID-19 within these settings.

**All efforts should be taken to limit the risk of COVID-19 transmission in these settings.**

The guidance applies to various congregate living settings identified in the [COVID-19 Action Plan: Vulnerable People](#).

- Adult correctional institutions are not included in the scope of this guidance document. Separate guidance has been created for corrections, in alignment with advice from the MOH and Public Health Ontario (PHO).
- Congregate living settings in a First Nation community should collaborate with the community's leadership, including Chief and Council, and if applicable the federal government and/or local public health unit, in order to determine the most appropriate ways to implement the recommendations provided in this guidance, including any processes to report and support COVID-19 outbreaks.

The guidance focuses on public health measures (i.e., non-medical interventions used to reduce the spread of disease). Different ministries with oversight for congregate living settings may provide additional sector or setting specific information and direction. Some additional sector specific information is included in a compendium document. This supporting document will be posted on MOH's website and maybe updated on an ongoing basis.

Please note that this document replaces the following previously released documents: Guidance for Group Homes and Co-Living Settings, Guidance for Homeless Shelters, and Guidance for Community-Based Mental Health and Addictions Service Providers in Residential Settings.

## General Advice

All congregate living settings should implement the public health measures set out in this document to help protect their residents, staff, and essential visitors against COVID-19. These measures should build on those that respond to other communicable diseases (e.g., influenza, measles). Many of these recommended measures will be part of existing organizational plans developed for disease outbreaks or other emergencies (e.g., pandemic and/or business continuity plans).

- Collaboration with other organizations is important in developing strong local, sector plans. For example, where appropriate, plans may be developed in partnership with multiple local agencies or the federal government for the safe isolation of residents who require testing, those awaiting test results, and/or those who have tested positive for COVID-19.

- Existing clinical relationships should be identified and expanded upon to facilitate clinical assessments of symptomatic residents, testing and clinical care.
- Wherever possible, employers should work with staff and unions (if applicable) to limit the number of work locations where staff work in order to minimize risk.
- In order to reduce the risk of COVID-19 transmission, only staff and essential visitors who have no symptoms associated with COVID-19 and pass screening, should be permitted in the congregate living setting. New resident admissions should be screened appropriately.
  - Policies should be developed that limit non-essential visitors to each congregate living setting to reduce risk of transmission of COVID-19.
  - An operational definition of an essential visitor should be developed and defined in the policy. This may include a person performing essential support services, such as health care services, a parent/guardian, a person visiting a very ill or palliative resident, or a maintenance worker.
- Congregate living settings should promote physical distancing between residents, staff and essential visitors – at a minimum 2 metres should be kept between all individuals regardless if they are well or unwell.

## Planning Activities

- It is important that congregate living settings review their services and operations to identify ways to reduce the risk of exposure to COVID-19.
  - Each congregate living setting should consider identifying a lead person to be responsible for infection prevention and control (IPAC) practices within the setting. This individual should take the lead in educating other staff, residents and essential visitors about IPAC practices, developing or reviewing policies and procedures, and should be involved in outbreak management activities. Please refer to PHO's [website](#) for additional resources.
- Policies and procedures related to outbreak management should be in place, reviewed, communicated and updated regularly (see section on Outbreak Management). These should include:
  - When to consult with the local [public health unit](#).
  - Staffing contingency plans including adequate staff to resident ratios.



- Communication requirements and processes (e.g., between the congregate living setting and the First Nation community (if applicable), the local [public health unit](#), residents, families of residents, the Public Guardian and Trustee, other key stakeholders).
- Enhanced cleaning activities, including the frequency of wiping down commonly touched and used items.
- General education, instruction and training about disease transmission and prevention should be reviewed regularly so that all residents, staff and essential visitors have the information to make the safest choices possible. A list of topics can be found in Appendix A.
- A training program to support the safe implementation of recommended precautions should be provided to all staff and essential visitors. It is the employer's responsibility to ensure all staff and essential visitors are instructed and trained on the safe use, limitations, conservation, as well as proper maintenance and storage of supplies and equipment, including but not limited to:
  - alcohol-based hand rub (ABHR)
  - personal protective equipment (PPE)
- Procedures should be in place to transfer the care of a resident, if at any time they are unable to safely support that resident because of COVID-19, including when they are self-isolating.
- Planning should also include:
  - How to leverage existing clinical relationships to support the care of ill residents. Residents who do not have a primary care provider may access clinical assessment through Telehealth Ontario at 1-866-787-0000.
  - How to make referrals to hospitals for residents who may require hospital care.
  - How to collaborate with specialized services that may be required for the care of residents (e.g., mental health services, harm reduction services/ supplies, medical services, nicotine replacement for those who may need it, addiction treatment services, including opioid agonist treatment (e.g., methadone, suboxone).

- Services provided should be delivered virtually if possible, and if not, maintaining physical distancing and avoiding face-to-face discussion. This could include medical appointments, support services, counselling, etc.
- How to convert existing spaces within the congregate living setting to increase physical distancing by considering:
  - Where appropriate, ways to reduce bed occupancy/number of residents.
  - Converting spaces (e.g., offices) into temporary single bedrooms to support residents who need to self-isolate.
- How and what services must be provided to residents who are self-isolating.
- How to access:
  - extra cleaning products that may be needed; and
  - other supplies or equipment that may be needed to continue to provide services to residents, such as PPE.

## Prevention of Disease Transmission

There are many things that congregate living settings can do to prevent and limit the spread of COVID-19; core among these are proper [hand hygiene](#), respiratory etiquette and physical distancing.

- Ensuring there are enough supplies for proper hand washing, including pump liquid soap in a dispenser, potable running water and paper towels or air dryers. If possible and appropriate, consider adding ABHR stations throughout the congregate living setting. Use ABHRs with 60% - 90% alcohol. ABHR should only be used when it does not cause harm to residents.
- Providing tissues and lined no-touch garbage bins (such as garbage cans with a foot pedal) are preferred for disposal.
- Posting [signage](#) throughout the setting reminding residents, staff, and essential visitors about the signs and symptoms of COVID-19, and the importance of measures such as proper hand hygiene, and respiratory etiquette.
  - Signage should be accessible and accommodating to residents and essential visitors (e.g., plain language, pictures, symbols, languages other than English and French).

- Moving furniture and creating visual cues such as tape on the floor to delineate 2 metre distances.
- Planning enhanced in-house/on the property recreation and structured activities that maintain physical distancing.
- For settings that are usually closed during the day (e.g., homeless shelters), considering extending hours/offering indoor or outdoor spaces (e.g., backyard, porch) to enable residents to maintain physical distances. This could help limit the time residents spend in the community where they may become infected.
- In shared bedrooms, space should be increased between beds to at least 2 metres apart. If this is not possible, consider different strategies to keep residents apart (e.g., place beds head to foot or foot to foot, using temporary barriers between beds).
  - Avoid using bunk beds.
  - Consider additional measures, such as private rooms or rooms with the fewest number of occupants.
- Facilitating interactions between residents and their family and friends through technology (telephone and video). Shared phones should be cleaned between uses or covered with a disposable plastic covering that is removed and thrown out after each use.

### **3. Cleaning and Disinfecting**

- In addition to daily routine cleaning, all high-touch surfaces that are touched and used frequently by residents, staff and essential visitors should be cleaned and disinfected at least twice a day and when visibly dirty (e.g., door handles, kitchen surfaces and small appliances, light switches, elevator buttons, television, remotes, phones, computers, tablets, medicine cabinets, sinks and toilets).
- Items that are used by different residents should be thoroughly cleaned between each resident use.
- Common areas including bathrooms, should be thoroughly cleaned and disinfected at least twice per day and when visibly dirty.
- Mattresses should be cleaned and disinfected between residents and clean bedding should be provided to all residents. Bedding should be cleaned on a regular schedule.

- Clean towels should be provided to each resident with instructions not to share. Hand towels should be replaced by single use paper towels.
- Cleaning should also be extended to the exterior of the congregate living setting if there is a concern that residents may pick up cigarette butts and other debris from the areas outside of the setting.
- Vehicles used for transporting residents should be cleaned between uses.

For more information and guidance on environmental cleaning, please refer to PHO's on [Cleaning and Disinfection for Public Settings](#).

#### **4. Routine Masking to Protect Others (for Source Control)**

- Non-medical masks are recommended as an additional measure for source control to help protect other individuals from exposure to the respiratory droplets of the person wearing the mask.
  - Non-medical masks help keep the wearer's droplets contained to protect others around them.
  - Science around the use of non-medical masks is evolving. Staff should refer to the Public Health Agency of Canada's (PHAC) [guidance](#).
- It is recommended that all staff and essential visitors wear non-medical masks when in the congregate living setting for the duration of their shifts or visits.
- Residents may also choose to wear non-medical masks, especially in areas where they may not be able to consistently maintain physical distancing (i.e., less than 2 metres from others).
  - Some congregate living settings may choose to encourage mask use by residents while in common spaces. For example, in short stay settings, where resident groups change frequently or where residents are anticipated to have numerous social interactions outside of the congregate living setting.
  - When developing policies on mask use by residents, consideration must be given to the safety of resident groups. PHAC's [guidance](#) has more information about populations that are not recommended to use masks.
    - Masks are not recommended for children less than 2 years of age.
    - Masks may not be tolerated by everyone based on underlying health, behaviour issues or beliefs.

- Congregate living settings should establish policies regarding the use of non-medical masks in the setting. Consideration should be given to mitigating any possible physical and psychological injuries that may inadvertently be caused by wearing a face covering (e.g., interfering with the ability to see or speak clearly, or becoming accidentally lodged in equipment the wearer is operating).
- Masks should be changed if visibly soiled, damp, or damaged.
- Education must be provided about the safe use, limitations and proper care (e.g., cleaning) of non-medical masks. See Ontario's [COVID-19 website](#) and [PHO's website](#) for additional information.

## 5. Masking during the Provision of Direct Resident Care

- Staff providing direct care to residents (e.g., care provided within 2 metres) should assess the need for PPE based on the nature of the planned interaction with a resident and what is known about the resident's health status.
  - If PPE is currently being used in the congregate living setting to support existing policies and procedures, this should continue.
  - With respect to [IPAC purposes](#) related to COVID-19 specifically, PPE should be used when providing direct care to residents who have symptoms or have tested positive for COVID-19.
- Additional guidance about the selection of PPE can be found in PHO's document on [Risk Algorithm to Guide PPE Use](#).
  - Non-medical masks are not considered PPE. Recommendations for the use of PPE are based on risk assessments of specific environments and risk of exposure.

## Screening

- All congregate living settings should undertake passive (using signage) and active (asking screening questions) screening for residents, staff and essential visitors.
- [Signage](#) should be posted on every entry door and throughout the congregate living setting to prompt anyone to self-identify if they feel unwell or screen positive for [signs and symptoms](#) of COVID-19.

## 1. Entry Screening for all Residents, Staff and Essential Visitors

- All individuals should be actively screened prior to entry. A formal process should be established to ensure rigorous screening activities. Settings may wish to adapt the screening tool found on the MOH's [COVID-19 website](#).
- During screening activities, organizations should consider:
  - Limiting points of entry into the setting to help facilitate screening.
  - Placing a physical barrier (e.g., plexiglass) that staff can be behind in order to conduct screening at entrances to protect from droplets.
  - Spacing and layout at the entrance so that physical distancing can be maintained while staff conduct screenings.
  - The need for medical (surgical/procedure) masks and eye protection, ABHR, tissue, and lined no-touch waste basket or bin to screening staff in situations where a physical barrier is not available and close contact with an individual is likely to occur.
  - Encouraging all residents, staff and essential visitors to use ABHR before entering.
- Staff and essential visitors who do not pass this screening should not be permitted to enter the congregate living setting.
- Residents who do not pass this screening should be directed to a designated space where they can self-isolate and wait for arrangements to be made for a clinical assessment.
- As part of screening, all residents, staff and essential visitors should be advised that if they start to feel unwell, they should immediately notify a designated individual (either staff or a supervisor).

**Emergency first responders should be permitted entry without screening.**

## 2. Screening New Admissions/Transfers

- Where possible, new admissions or transfers should be screened over the phone for [signs and symptoms](#) of COVID-19 before admission (intake).

## Long Stay Settings

- Where operationally feasible, all new admissions or transfers into long stay settings (i.e., where residents are anticipated to stay for more than 14 days) should be tested for COVID-19 prior to admission. Regardless of the test results, new residents should also [self-isolate](#) for a period of 14 days upon arrival.
- Settings should consider whether it is necessary, safe and operationally appropriate to postpone the admission of those who test positive (under the advice of the local [public health unit](#) provided through case management activities). If admission is postponed, individuals should be referred to other organizations or services in the community where they can be housed for the self-isolation period.

## Short Stay Settings

- If pre-admission screening is not possible/feasible, congregate living settings should screen in-person on arrival (see above).

### 3. Daily Screening of Residents, Staff and Essential Visitors

- All residents, staff and essential visitors should be instructed to [self-monitor](#) for COVID-19 [signs and symptoms](#) and inform staff or their supervisor as soon as they begin to feel unwell.
  - Staff should monitor residents that are unlikely to recognize or understand the importance of reporting symptoms and those who may not be able to self-monitor such as children and adults with developmental disabilities.
- Residents, staff and essential visitors should be screened twice daily for COVID-19 [signs and symptoms](#). Where operationally feasible, this could include temperature checks. Staff and essential visitors should be screened at the start and end of each shift or visit.
- Congregate living settings will need to consider how to operationalize these recommendations within their existing policies, procedures and other requirements.

### 4. Positive Screening: What to do

- If a resident develops [signs and symptoms](#) of COVID-19, they should be placed in a single room with a door that closes.

- If this is not feasible and they may come into contact with others, they should be placed in an area away from other residents and given a medical (surgical/procedure) mask to wear if it is safe for the resident.
- Staff should try to maintain physical distance between themselves and the resident (i.e., 2 metres or more) while monitoring and providing assistance to them.
- Congregate living settings should consider procedures for:
  - How and where the resident can be clinically assessed.
  - How testing can be arranged (e.g., assessment centre, health care provider on site). Information about assessment centres is located on the MOH's website.
  - For congregate living settings that have identified in their planning that they can not safely house someone who is self isolating for COVID-19, how to transfer them to a designated location.
  - What to do if a resident develops severe symptoms.
- If staff or an essential visitor develop [signs and symptoms](#) of COVID-19, they should tell their supervisor immediately and separate themselves from others.
- Staff who have been advised to self-isolate should notify their supervisor or the administrator of the congregate living setting.

## Caring for Residents that need to Self-Isolate

- New admission in long stay settings, as well as residents who are unwell, those awaiting test results and those who have tested positive for COVID-19 should [self-isolate](#).
- Any resident who needs to [self-isolate](#), should be placed in a single room with a door that closes and if feasible, have access to a private bathroom.
- If there is not enough space in the congregate living setting for the resident to [self-isolate](#), the resident may be grouped (cohorted) with others who are in the same situation (e.g., group those who are unwell/symptomatic), while maintaining as much distance as possible from other individuals or groups (e.g., those who are not ill).



- Staff providing direct care should take appropriate precautions depending on the nature of the planned interaction and what is known about the health status of the resident. See [Risk Algorithm to Guide PPE Use](#).
  - See PHO's [Droplet and Contact Precautions Non-Acute Care Facilities](#) for additional information.
- Congregate living settings should consider:
  - How to protect staff who need to provide care to the resident, and how to decide when PPE will be needed.
  - How to isolate the resident in a private room for a period of 14 days or until they no longer have symptoms.
  - How to support the resident remaining in their room, including the ability to receive meals in their room, and, if possible, not sharing a bathroom with others.
  - If strict self-isolation is not feasible, a medical (surgical/procedure) mask should be provided to the resident if safe and tolerated, for the entire time they are outside of their room (including when accessing a shared bathroom). Everyone should perform hand hygiene when putting on and taking off their mask.
  - How to maintain physical distancing, staggering access, and undertaking thorough cleaning and disinfection to common spaces when the unwell resident uses common facilities.
  - Who will monitor the resident's symptoms and how often this will be done, how it will be logged, and how to determine when additional medical care and intervention is required.
  - How to access transportation (not public transportation) if there is a need to move the resident between locations.

## Reporting

- COVID-19 is designated as a disease of public health significance (O. Reg. 135/18) and thus reportable under the [Health Protection and Promotion Act](#) (HPPA).
- In addition to any duty to report a suspected or confirmed case of COVID-19 under the [HPPA](#) and other legal reporting requirements, administrators of all congregate living settings are encouraged to contact their local [public health unit](#)

if a resident, staff or essential visitor has or may have COVID-19 to facilitate timely contact tracing and outbreak management within the setting.

- It is important to indicate the type of care setting to the local [public health unit](#) as they are tracking cases within congregate living settings.

## Outbreak Management

- An outbreak within a congregate living setting is defined as one laboratory confirmed case in a resident or staff. Outbreaks are declared by the local medical officer of health or their designate in coordination with the administrator of the congregate living setting.
- Once an outbreak has been declared, the local [public health unit](#) will direct testing and associated public health management of all those impacted (staff, residents, essential visitors).
  - If large numbers of residents require testing, the local [public health unit](#) and the congregate living setting administrator may collaborate to make arrangements to either bring testing services to the setting or make arrangements with the local COVID-19 Assessment Centre.
- The local [public health unit](#) will provide guidance with respect to any additional measures that should be implemented to reduce the risk of COVID-19 transmission in the setting.
- As part of the outbreak management process, the congregate living setting should notify individuals/agencies about the outbreak as listed in the setting's procedures and policies.
- Residents, staff and essential visitors should be made aware of the outbreak measures being implemented at the congregate living setting.

### 1. Control Measures

Control measures are any action or activity that can be used to help prevent, eliminate or reduce a hazard. Once an outbreak is declared, the local [public health unit](#) will provide direction to the congregate living setting to help manage the outbreak, and the control measures they should implement. This includes:

- Defining the outbreak area (i.e., affected unit(s) or the whole congregate living setting) by:

- Considering all residents in the outbreak area to be either infected or exposed and potentially incubating.
- Cohorting all residents in the outbreak area as much as possible.
- Having staff in the outbreak area work with only one group of residents on each shift if possible.
- Providing direction on how staff can protect themselves when interacting with residents in the outbreak area.
- Providing in-room tray service meals within the outbreak area to avoid communal dining.
- Undertaking enhanced cleaning practices.
- Limiting or restricting new admissions:
  - Best practice is that no new resident admissions should be allowed into the outbreak areas until the outbreak is declared over.
  - Depending on the services provided by the congregate living setting, new admissions/re-admission may be required during an outbreak. In such instances, the administrator should connect with the local [public health unit](#) for guidance.

## 2. Personal Protective Equipment (PPE)

- The selection of PPE should be based on the nature of the interaction with the resident and/or the likely mode(s) of transmission of infectious agents. Selection of appropriate PPE should be based on a risk assessment (e.g., type of interaction, status of resident) that dictates what is worn to help break the chain of transmission. More guidance about the selection of PPE can be found in PHO's document on [Risk Algorithm to Guide PPE Use](#).
- In addition to other precautions as dictated by the nature of the patient interaction, see PHO's guidance on [IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#).
  - An N95 respirator is only recommended if an [aerosol-generating medical procedure](#) is being performed (this is unlikely to be required in most congregate living settings).

- Staff should wear a medical (surgical/procedure) mask, eye protection and gown when in the outbreak area where resident interactions are possible. Gloves are donned when providing direct care and hand hygiene performed when removed. See [Droplet and Contact Precautions](#). Gowns should not be worn in non-care areas such as staff-only areas or break rooms.
- Congregate living settings should ensure that an adequate supply of PPE is available for staff and essential visitors.

### 3. Declaring the Outbreak Over

The local medical officer of health or their designate will declare when the outbreak is over.

Generally, an outbreak is declared over when there are no new cases of COVID-19 in residents or staff after 14 days.

## Occupational Health and Safety

- Employers have obligations under the [Occupational Health and Safety Act](#) (OHSA) to protect the health and safety of their workers<sup>1</sup>, including from the transmission of infectious disease in the workplace.
- If COVID-19 is suspected or diagnosed in staff, return to work should be determined by the individual in consultation with their health care provider and the local [public health unit](#), based on provincial guidance. Detailed occupational health and safety guidelines for COVID-19 are available on the MOH [COVID-19 website](#) and the Ministry of Labour, Training and Skills Development [website](#).

## Appendix A – General IPAC Education Topics

- The ongoing education of staff, essential visitors and residents about infection and outbreak prevention and related strategies is crucial to help control the spread of COVID-19. The congregate living setting should also implement COVID-19 screening measures for all residents, staff and essential visitors.
- Education for staff should include education/orientation programs and should include information and review of:
  - Information about COVID-19, including [prevention](#) and transmission.
  - The strategies to reduce disease transmission, such as [respiratory etiquette](#) and [hand hygiene](#).
  - Outbreak management and staff exclusion policies in the congregate living setting (as required).
  - Policies related to staff and essential visitors who may be experiencing symptoms of respiratory illness and should not be working or visiting the setting.
  - IPAC competencies and resources. See PHO's [website](#) for resources.
  - Current Ministry of Health and Public Health Ontario guidance and training resources on IPAC (including as they evolve and are updated).

### Education for residents:

- Information about COVID-19, including prevention and transmission.
- Residents should be reminded about the importance of hand hygiene, respiratory etiquette, and physical distancing.
- Discourage residents from sharing items with other residents that touch the mouth or nose (e.g., personal care items, straws, utensils, cigarettes, drinks, vapes, drug paraphernalia).
  - Items such be labelled with the resident's name.

## Hand Hygiene

- Hand hygiene should be performed often and especially before and after:
  - After entering the facility.
  - Before and after touching surfaces or using common areas or equipment.

- Before eating.
- Before and after preparing food.
- Before touching the face (including before smoking).
- After using the bathroom.
- Ensure supplies (i.e., liquid hand soap, ABHR, paper towels/tissues, garbage cans) are easily accessible and regularly maintained. Avoid use of bar soap.
- Disposable paper towels are preferred, but cloth towel that is only used by one person may be used.
- Designate a sink for staff hand washing (if possible).
- Avoid touching the face, eyes, nose, and mouth at all times, especially with unwashed hands.

## Respiratory Etiquette

- When coughing or sneezing, all individuals should:
  - Turn their head away from others.
  - Cover their nose and mouth.
  - Cough or sneeze into sleeves/bend of the arm and not hands or use a tissue.
  - Disposing of used tissues as soon as possible in a lined, non-touch waste basket or garbage bin, followed by performing hand hygiene.

## Appendix B – Additional Resources

### Public Health Ontario – Public Resources

<https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/public-resources>

### COVID-19 Preparedness and Prevention in Congregate Living Settings - English

<https://www.publichealthontario.ca/-/media/documents/nCoV/cong/2020/05/covid-19-preparedness-prevention-congregate-living-settings.pdf?la=en>

### Managing COVID-19 Outbreaks in Congregate Living Settings - English

<https://www.publichealthontario.ca/-/media/documents/nCoV/cong/2020/05/managing-covid-19-outbreaks-congregate-living-settings.pdf?la=en>