Infection Prevention and Control
Outbreak Response Checklist for Acute Care Facilities

This checklist is intended to be used by facilities after and in response to a suspect or confirmed COVID-19 outbreak having been declared. It should be completed by the unit manager or designate in collaboration with local Infection Prevention and Control (IPAC) or Public Health (PH).

Fax/e-mail completed checklist within 24 hours of declared outbreak to your local Infection Prevention and Control Department. Any items with a status marked "partial" or "no" should be discussed and progress noted during the outbreak daily huddle.

Facility Name: **Area (if applicable):**		
Contacts	**Name**	**Phone Number**
Facility Contact/Manager:		
Infection Control/Public Health:		
Medical Health Officer (MHO):		
Employee Health (EH)/OHS:		
Environmental Services:		
Lab:		
Materials Management:		

Date Declared - Suspect Outbreak: _____ Confirmed Outbreak: _____

Outbreak #: _____ Total Number of Patients on Outbreak Unit: _____

	Don't Wait... ISOLATE!	**Status**				**Comments**
		Yes	**Partial**	**No**	**N/A**	*Provide for "Partial" and "No"*
1.0	Isolation of Index Case(s)					
	Staff Case					
1.1	Lab confirmed staff member excluded from work until released by PH					
	Patient Case					
1.2	Lab confirmed COVID-19 patient placed on Droplet/Contact Plus[1] precautions					
2.0	Identification of Contacts/Contact Tracing					
2.1	Roommate(s) of case are identified and placed on Droplet/Contact Plus precautions • In multi-bed rooms, move the well, exposed patient to a private room (Note: Exposed roommate should not be transferred to any other multi-bed room for 14 days from last exposure)					
2.2	Initial assessment performed of all patients for symptoms of COVID-19 and all symptomatic patients placed on Droplet/Contact Plus precautions					

[1] Discontinue precautions as per Acute Care Placement and Precautions Algorithm and Management of COVID-19 Recovered Patients

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		Yes	Partial	No	N/A	*Provide for "Partial" and "No"*
2.3	IPAC or PH identifies patient close contacts to the confirmed case(s). Refer to the following documents: CV-19 G0032 Acute Care and Continuing Care COVID-19 Contact Definitions CV-19 WS0032 Assisting IPAC with Contact Education and Information Gathering SHA 0050 Acute Care COVID-19 Close Contact Instructions SHA 0051 Acute Care COVID-19 Non-Close Contact Instructions CV-19 G0070 Risk Classification for Patient Exposures to COVID-19 in Health Care Settings					
2.4	Patient close contact(s) placed on Droplet/Contact Plus precautions					
2.5	Notified facilities (Acute or LTC) where patient close contacts had been transferred or discharged to in the last 14 days					
2.6	Unit provides a list of all visitors that had contact with case to PH					
2.7	A list of staff who worked with the case has been provided to EH and/or IPAC to determine whether the staff is a close or non-close contact (include on the list those staff who are now working on or scheduled to work on other units)					
2.8	Keep a log of visitors and staff and retain for contact tracing (Refer to SHA 0072 COVID-19 Screen Form Log - Repeat Visits)					
3.0	Line Lists					
3.1	A Patient Line List has been initiated to include symptomatic patients. Send daily to IPAC/PH					
3.2	A Staff Line List has been initiated to include any staff symptomatic and off-sick (COVID-19 related). Send daily to Employee Health/OHS and IPAC/PH • All sick calls from staff should be screened for symptoms of COVID-19 and added to line list, if symptoms compatible					
4.0	Patient Placement/Additional Precautions/Personal Protective Equipment					
4.1	For suspect and confirmed outbreaks, only the patient case, patient(s) deemed close contacts and those with symptoms are placed on Droplet/Contact Plus precautions					
4.2	Confirmed COVID-19 patients have been placed in private rooms and cohorted in a section/wing of the unit If private rooms are not available, may cohort confirmed COVID-19 patients in shared rooms (Refer to IPAC Recommendations for Cohorting Patients on Additional Precautions in Acute Care)					

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4.3	Droplet/Contact Plus precautions signage has been posted on doorway of rooms, where required					
4.4	Garbage and/or linen hamper has been placed inside of the room near the exit					
4.5	PPE removal poster has been placed inside the room, ideally above garbage and/or linen hamper					
4.6	Appropriately stocked PPE carts/tables have been placed (e.g., masks, goggles (non-vented or indirectly vented) or face shields, gowns and gloves) outside room. Ensure there are sufficient quantities to last a minimum of 72 hours • All PPE should be kept off the floor • Refrain from folding gowns (i.e., keep in bag)					
4.7	Continuous eye protection (face shield or goggles) required for all staff providing direct care or anticipating contact with any patients on the outbreak unit (regardless of whether the patient is on precautions)					
4.8	Staff don/doff PPE following: • Continuous and Extended PPE Use Guidelines Acute Care or PPE Guidelines When Caring for Patients/Residents Confirmed to Have COVID-19 in Designated Units/Cohorted Spaces • Putting on (Donning) PPE • Taking off (Doffing) PPE • Disinfecting Face Shields • COVID Rapid Safety Update - AGMPs					
4.9	Alcohol based hand rub (ABHR) is ready accessible to staff at point-of-care and at all entrances to the facility					
4.10	Staff have reviewed and know when and how to perform hand hygiene according to the SHA Hand Hygiene Policy					
4.11	Disinfectant wipes are readily available at room entry and throughout the facility					
4.12	Soap, paper towel and ABHR dispensers are checked daily and replaced as needed					
5.0	Specimen Collection & Transport					
5.1	Specimens collected from all symptomatic (including mild or atypical symptoms) patients • If negative, repeat swab 48 hours later • For more information on testing, specimen collection and lab requisitions, refer to COVID-19 Testing					
5.2	Expanded testing of all other patients and staff as directed by MHO or designate[2]; at a minimum all individuals identified as close contacts should be tested for COVID-19					
5.3	It is recommended that all deaths that occur during the outbreak regardless of symptoms are swabbed and tested for COVID-19 (Refer to Death, Care of the Body in PUI or Confirmed COVID-19)					

[2] Designate may be Infection Control Officer (i.e., Medical Microbiologist, Infectious Disease Physician) in acute care setting

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6.0	Ongoing Monitoring and Containment					
6.1	Patients monitored once per shift (twice daily) for signs and symptoms (S&S) of COVID-19 (consider documenting on Signs and Symptoms Daily Monitoring Form – Acute Care)					
6.2	Affected unit doors are closed to discourage traffic through the affected areas and to separate from other unaffected areas					
6.3	COVID-19 Outbreak Unit poster is posted at entry to area in outbreak					
6.4	Risk reduction strategy implemented for ill patients who can't/unable to remain in their room – think **MR.CLEAN**[3] **M**ask (as tolerated) **R**edirect back to their room **C**lean their hands **L**ead others away (keep sick away from the well) **E**nvironmental cleaning of areas they are in **A**ll staff can help **N**o go (visual barriers)					
7.0	Communication and Cancellations					
7.1	COVID-19 Outbreak Response Team (C-ORT) assembled and meets daily[4] (initially) to discuss and review the situation until the outbreak is declared over (Refer to COVID-19 Outbreak Guidance for Acute Care Facilities for sample outbreak daily huddle agenda)					
7.2	Communication plan/notification strategy initiated for staff • Notify staff through usual process (i.e., phone calls, e-mail, text) Remind staff: • Be diligent with hand hygiene • Change uniforms at work • Leave shoes at work					
7.3	All departments notified of outbreak status (includes laundry, food & nutrition, therapies, environmental services etc.)					
7.4	Family presence has moved to Level 3 (restricted to End of Life only). Those permitted to enter the facility must be screened as per SHA facility screening guidelines					
7.5	Encourage alternate means of communication/virtual visitation between patients and family/friends (e.g., iPad, FaceTime)					
7.6	Outside contractors scheduled to perform work on the outbreak unit cancelled/rescheduled unless the job is urgent or related to resolving the outbreak (i.e. oxygen, respiratory equipment)					

[3] Reference: Pandemic Plan Checklist for Continuing Care – Annex R

[4] Frequency of meetings may be reduced once the outbreak preventive measures are in place and no further transmission has been reported

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8.0	Staff Cohorting					
8.1	Staff working in affected area are cohorted to the unit/wing until the outbreak has been declared over, where possible					
8.2	Direct care staff are cohorted to either infected or non-infected patients within the outbreak area. If not possible, at a minimum: • Staff providing care to ill patients does not assist with feeding or deliver meals to well patients					
8.3	Staff working in affected outbreak area take breaks separate from staff who work in unaffected areas					
8.4	Staff contingency plan implemented to ensure minimum staffing needs and essential operations in the facility					
9.0	Admissions/Transfers/Discharges					
9.1	Outbreak unit(s) closed to new admissions and transfers or as per MHO/designate					
9.2	If inter-facility or intra-facility transfer is required, advise EMS and/or receiving department/facility: • Patient coming from a COVID-19 outbreak unit (If admitted to another facility, advise if patient is COVID-19 positive (case), symptomatic and undiagnosed or a close contact) • Maintain Droplet/Contact Plus precautions during transport • If the patient will tolerate a mask, have them wear one Note: These measures apply to all patients leaving the outbreak unit, including those patients not currently on precautions					
9.3	If a patient is ready for discharge back to the community, consult with Public Health/designate for direction on whether they need to self-isolate or self-monitor. Patients will be provided with the appropriate information sheets prior to discharge • Notify Home Care, if patient is a close contact and is to receive services after discharge					
9.4	Requests for discharge to Long Term Care/Personal Care Home must be discussed with the MHO/designate (Refer to COVID-19 Testing-Move-in to LTC or Personal Care Home from Acute Care or LTC)					
10.0	Equipment Cleaning					
10.1	Process is in place to clearly identify clean and dirty patient equipment (e.g., tags marked "I am clean"). Ensure clear separation between clean and dirty carts and equipment					
10.2	Review and identify which surfaces/items care staff is responsible for cleaning					

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10.3	All equipment that is shared between patients has been cleaned and disinfected (remember to clean the entire piece of the equipment and not just the area that comes into contact with the patient) • When possible, equipment should be dedicated to a single patient					
10.4	Increased cleaning of high touch surfaces - minimum 2 times per day: • Patient wheel chairs - hand contact areas • Telephone/keyboard/desk and chair arms/backs at Nursing Station • Med carts - hand contact areas					
11.0	Enhanced Cleaning (Environmental Services)					
11.1	Environmental services staff are cohorted, if possible. If unable to cohort and staff must move between areas, they are to avoid contact with the ill patients and visit the outbreak unit last					
11.2	Cleaning is always performed from clean areas to dirty areas. Clean additional precautions rooms last					
11.3	Increased cleaning of high touch surfaces in ill patient rooms and all common areas of the affected unit - ****minimum 2 times per day****. This includes but is not limited to: • Staff and public bathrooms (sinks/taps/toilets) • Hand rails/stair rails • Call lights/bed rails/overbed table • Light switches/elevator buttons • Door knobs, push plates • Common area TV remotes/public phones					
11.4	Terminal clean of the room is completed when additional precautions are discontinued • In multi-bed rooms (2, 3 or 4 bed rooms), all beds and bed spaces require a terminal clean					
11.5	Rooms and surfaces are free of clutter to enable easy cleaning and disinfection of surfaces (e.g., hallways, nursing stations, patient rooms etc.)					
11.6	If patient experiences GI symptoms (i.e., diarrhea, vomiting), Hygenic/Zorbie bags could be considered					
11.7	Clean linen covered and kept away from contaminated items (e.g., dirty linen hampers, garbage bins)					
11.8	Indoor garbage cans have foot release or lid removed					
12.0	Food Service Delivery					
12.1	Dietary staff have no contact with ill patients (this includes the delivery of food trays)					
12.2	Staff perform hand hygiene between assisting patients during meals as per the 4 Moments for Hand Hygiene					
12.3	Staff ensure and assist (when necessary) all patients with hand hygiene before eating using ABHR					
12.4	Well patients are served first followed by the ill patients, if staff are unable to be appropriately cohorted					

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12.5	Regular dishes and cutlery are used (i.e., disposable not required). No special precautions required for handling of dishes (i.e., bagging of the dishes is not required)					
12.6	Automatic ice dispensing machines are used by staff only (i.e., bulk ice machines with a scoop are not to be used)					
12.7	Holding carts and dish trolleys (including the wheels) are cleaned and sanitized as per local processes					
12.8	Kitchenettes on units are restricted to staff use only during the outbreak					
13.0	Staff Break Rooms					
13.1	Breaks and lunches are staggered to help ensure two metre physical distancing of staff and to limit the number of potential contacts in the event of an exposure					
13.2	Disinfectant wipes and ABHR are readily available in break rooms					
13.3	The tables and chairs in staff break rooms have been reduced to accommodate physical distancing. A sign has been posted to indicate the number of allowable staff at one time. Tables and chairs have been placed two metres apart					
13.4	Table and arms of chair are disinfected before/after use					
13.5	No sharing of food or drinks					
13.6	No communal food(s)/food left in fridge at shift end					
13.7	Refrigerators and cupboards are free of all but single-serving items					
13.8	Shared items from staff room (i.e., magazines) have been removed					
14.0	Staff Common Areas (e.g., Med rooms, nursing station etc.)					
14.1	Food and drinks consumed in designated areas only (not at nursing stations or in med rooms)					
14.2	Meeting spaces allow for 2 metre physical distancing between attendees (i.e., during report out)					

Adapted from Saskatoon Health Region COVID-19 Outbreak Checklist and Draft LTC COVID-19 Outbreak Checklist