Coronavirus COVID-19

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In light of the global COVID-19 pandemic and the increase in cases in Québec, please find below information and guidelines on creating buffer zones.

Buffer zones are transition areas where patients go before being transferred to their residential facility—be it a residential and long-term care centre (CHSLD), intermediate and family-type resource (IR-FTR), private seniors' residence (PSR), continuous assistance residence (CAR), or other facility. These zones are also used to isolate patients who have tested positive and cannot be isolated in their residential facility in accordance with the instructions and guidelines. Buffer zones prevent COVID-19 from spreading in residential facilities and keep patients from staying in the hospital any longer than necessary.

Buffer zone creation and guidance are subject to change as the pandemic evolves. The scope of the measures can be tailored to your local and regional pandemic profile and how care and services are organized.

This directive complements the decision-making algorithms for the following pathways:

- Pathway: Admission and stay in a designated or non-designated rehabilitation facility (physical impairment, physical health, and moderate rehabilitation)
- Pathway: Admission or return to a CHSLD after a stay in a hospital or rehabilitation facility or admission to a CHSLD from the community
- Pathway: Integration/reintegration into an IR-FTR, PSR, CAR, or other residential facility after a stay at a hospital or rehabilitation facility or integration into an IR-FTR, PSR, CAR, or other residential facility from the community

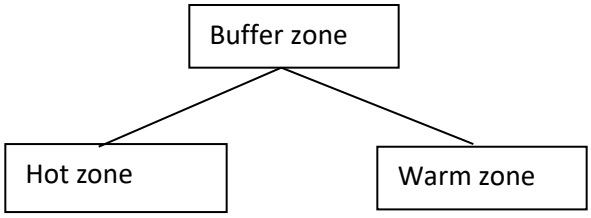
BUFFER ZONE GUIDELINES

A buffer zone may be in an existing facility or in a non-traditional site (NTS) depending on how services are organized in the region.

Different types of buffer zones can be created within the same area, since the physical environment must be adapted to meet patient needs. For instance, one buffer zone can be used for patients with a needs profile corresponding to admission to a CHSLD and another for patients with a needs profile corresponding to admission to an IR-FTR, a PSR, a CAR, or another facility.

Buffer zone setup: Hot and warm zones

The premises are to be divided into two separate zones such that patients and staff cannot move between them.



The hot zone is for patients with COVID-19, and the warm zone is for patients who have tested negative but may develop symptoms.

The hot and warm zones must be separate and clearly marked (entrances, exits, dressing and undressing area, meal and break area, area for preparing medication, and equipment storage) so that employees in each zone do not come into contact with each other.

In the buffer zone, staff must wear a medical mask and eye protection at all times. When in direct contact with patients, staff should also wear a gown and gloves in either the hot or warm zone. Personal protective equipment must be available in sufficient quantities and used properly and judiciously.

Patients sent to buffer zones

The hot zone is for patients who have tested positive for COVID-19 and cannot be isolated for the prescribed 14 days in their residential facility or cannot be isolated due to their clinical profile.

The warm zone is for patients who have tested negative and cannot be isolated for the prescribed 14 days in their residential facility due to its physical configuration or cannot be isolated due to their clinical profile.

The following patients do not need to go to buffer zones:

- Those who have recovered from COVID-19[1] following acute care and those who come from the community.

- Those who have tested negative for COVID-19 and whose residential facility (CHSLD, IR-FTR, CAR, or PSR) or rehabilitation facility is able to apply isolation and infection prevention and control (IPC) measures.

For further details, see the pathways.

Patients staying in buffer zones

Each patient should have a single-patient room with private bathroom if possible. This physical separation is particularly important in keeping patients in warm zones from being infected. Protective equipment against droplet-contact transmission (gown, gloves, medical mask, and eye protection) must be removed before leaving the room to avoid contamination.

Patients who develop symptoms while in the warm zone must be tested and kept in the warm zone pending test results.

Particular attention must be paid to COVID-19 negative patients who must be transferred to a warm zone that exhibit wandering behaviour or are unable to understand lockdown instructions and contamination risks. An agreement must be made with the family on the measures to be taken.

The signs, symptoms, and particular characteristics of patients must be monitored (for the elderly, see the relevant appendices in the CHSLD guidelines).

Buffer zone staff

Dedicated staff should be assigned to each zone (hot and warm).

The number of people working with a patient is to be limited.

There must be sufficient staff to meet patient needs and ensure the quality of care and services.

Employee health must be checked before each shift (e.g., by using a symptom monitoring grid).

Staff should be trained in best practices in infection prevention and control (IPC) for the zone to which they are assigned, as well as be clinically trained to meet the needs of older patients in the context of COVID-19.

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1 Recovery criteria: • At least 14 days since the onset of acute illness (CIDRAP, 2020) or 21 days for patients on corticosteroids, on immunosuppressants, or in intensive care; • No fever for 48 hours without the use of fever reducers; • 24 hours with no acute symptoms; • Negative PCR on at least two consecutive respiratory samples taken 24 hours apart after resolution of acute illness.

The goal should be 100% hand hygiene compliance.

- This means that staff wash their hands whenever recommended (upon entering and leaving the facility, before and after touching their mask, before and after entering a person's room, before and after providing care, after contact with body fluids, etc.).

A protocol for cleaning and disinfection of shared care equipment and physical premises must be implemented and followed. High-touch surfaces must be cleaned and disinfected several times a day.

An on-site manager designated as the IPC officer must take action to correct any non-compliance. They must also ensure that best practices are followed at all times. The manager may be supported by a person trained in IPC.

This document was produced by Ministère de la Santé et des Services sociaux du Québec. The information it contains is based on current knowledge related to COVID-19 as of May 21, 2020. This document will be updated as required.