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4.0 Guidelines for Common Communicable Diseases Child Care Centre

Resources

- Non Reportable Critters
- Non Reportable Diseases
- Reportable Diseases

5.0 Glossary of Terms

6.0 Works Cited
Purpose
The purpose of this document is to provide supporting information for Infection Prevention and Control (IPAC) programs in child care centres. Literature reviews were conducted to identify best practices for this type of setting. This document addresses major components of an IPAC program at child care centres and is not intended to address every possible circumstance.

Background
A number of agencies provide support and guidance to child care centres.

City of Toronto ("City") Children's Services is designated as the City's "child care service system manager" under provincial legislation and has responsibility for planning and managing a broad range of child care services. These services include: fee subsidy, wage subsidy, family resource centres, special needs resourcing and summer day camps. Children's Services also conducts quality assurance assessments of child care centres under service contracts for fee subsidy.

The Ministry of Education oversees the licencing of child care centres and the enforcement of the Child Care and Early Years Act (CCEYA), 2014 and relevant regulations. The purpose of the Act is to "foster the learning, development, health and well-being of children and to enhance their safety" (CCEYA, S.O. 2014, s. 1 [1]).

Public health units (PHUs) are under legislative authority to inspect institutions, including child care centres, as outlined in the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c.H.7. During inspections of child care centres, public health inspectors may make recommendations for the purposes of ensuring the health and safety of children. Accordingly, child care centres must comply with these recommendations as outlined by Ontario Regulation 137/15 (O. Reg. 137/15), made under the CCEYA, 2014. In particular O. Reg. 137/15 requires child care centres to:

1) "ensure that any recommendation or instruction of a medical officer of health [or designate, i.e., public health inspector] with respect to any matter that may affect the health or well-being of a child receiving child care at a child care centre the licensee operates is carried out by the staff of the child care centre" (s. 32 [1]); and

2) "ensure that, where a report is made by the local medical officer of health or any person designated by the local medical officer of health or the local fire department with respect to a child care centre operated by the licensee or a premises where it oversees the provision of home child care, one copy of the report is kept on the premises of the child care centre or home child care agency and another copy is sent immediately to a program adviser" (s. 32 [2]).
The Ministry of Health and Long-Term Care, under the HPPA (1990), publishes guidelines and standards for public health units. The Ontario Public Health Standards contains three key protocols which apply to child care centres:

- Infectious Diseases Protocol (2013) outlines requirements for the prevention and management of infectious diseases of public health importance
- Institutional/Facility Outbreak Prevention and Control Protocol (2008) requires the prevention, detection, and management of outbreaks in institutions including child care centres

Public Health Rationale

Public health involvement is required to reduce the rate of gastrointestinal, respiratory and other infectious and communicable illnesses in child care centre settings (Ejemot et al. 2008; Kotch et al. 2007; Ponka et al. 2004). The association between child care centre attendance and increased risk of common infectious diseases is well documented (Lu et al. 2004; Johansen et al. 1988). Child care centre attendance significantly increases the risk of diarrhoeal illness and upper respiratory tract infections among preschool children, especially in children less than 18 months of age (Lu et al., 2004; Johansen et al., 1988). There are also related economic and health care costs, including physician and emergency department visits and hospitalizations, and lost workdays by parents and caregivers (Bell et al., 1989; Carabin et al., 2000).
Routine Practices

Routine Practices are based on the premise that everyone is potentially infectious. Routine practices are universally recognized strategies to prevent and control infection. They must be routinely used with everyone to prevent exposure to all bodily fluids and excretions. Routine Practices are best practices that, when applied consistently, will reduce or eliminate the risk of transmission of microorganisms.

As part of Routine Practices, child care centre operators and staff must continually assess the risk of exposure to bodily fluids and excretions in their activities and identify strategies that will decrease these risks and prevent the transmission of microorganisms that can cause disease. Reducing or removing the risk of disease transmission must be incorporated into the culture of the facility.

For more details please refer to the PIDAC website: (http://www.oahpp.ca/resources/pidac-knowledge/best-practice-manuals/routine-practices-and-additional-precautions.html).
1.0 Immunization and Tuberculosis

1.1 Immunization Requirements for Children

Under the Child Care and Early Years Act, Section 35 (1) of O. Reg. 137/2015 (General) requires that, every licensee shall ensure that before a child is admitted to a child care centre, the child is immunized as recommended by the local medical officer of health.

All children who attend child care centres should be immunized according to Ontario’s Publicly Funded Immunization Schedule.

Table 1: Ontario’s Publicly Funded Immunization Schedule, 2015

- Children should receive their vaccinations according to age.
- Refer parents to their doctor or health care provider for a copy of their child's immunization record or to update any missing vaccines for their child.
- Every time a child gets vaccinated, parents should report this information to the child care centre operator who will update the child's file.
- Operators can contact Toronto Public Health at 416-392-1250 for free translation of foreign immunization records, interpreter services or more information on childhood vaccines and schedules.
### 1.2 Immunization Requirements for Staff

Under Section 57 (1), O. Reg. 137/2015 every licensee of a child care centre shall ensure that, before commencing employment, each person employed in each child care centre it operates has a health assessment and immunization as recommended by the local medical officer of health.

Toronto’s Medical Officer of Health recommends immunizations, listed below, for child care centre staff. The operator must collect and maintain the information on file at the facility. Students and volunteers are also recommended to receive these immunizations.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendations for staff, students &amp; volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>children with hepatitis B may not show symptoms and hepatitis B status may not be known; all staff should be vaccinated</td>
</tr>
<tr>
<td>Influenza</td>
<td>annually, especially for those who care for children under 5 years of age</td>
</tr>
<tr>
<td>Measles</td>
<td>2 documented doses of MMR vaccine or proof of immunity</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
</tr>
<tr>
<td>Rubella (MMR)</td>
<td>2 documented doses of MMR vaccine or proof of immunity</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>1 dose of Tdap in adulthood (This can replace the next scheduled dose of Td)</td>
</tr>
<tr>
<td>Tetanus</td>
<td>Tetanus and diphtheria (Td) vaccine booster every 10 years</td>
</tr>
<tr>
<td>Pertussis (Tdap)</td>
<td></td>
</tr>
<tr>
<td>Varicella (chickenpox)</td>
<td>2 doses of chickenpox vaccine given at least 6 weeks apart or proof of immunity. Previous immunity can be determined by a self-reported history of chickenpox or a blood test</td>
</tr>
</tbody>
</table>

Staff, students and volunteers should see their health care provider to determine their immunization status and to obtain any missing vaccines.

### 1.3 Immunization Exemptions

Exemptions are to be documented and kept in the child’s or employee’s file:

- For medical exemptions, a legally qualified medical practitioner must provide medical reasons in writing as to why the child should not be immunized.

- For religious or philosophical exemptions such as a parent who chooses not to immunize their child, "on the ground that the immunization conflicts with the sincerely held convictions of the parent’s religion or conscience" can submit their objections in writing.
• The same exemptions for medical, religious or philosophical reasons also apply to staff of the child care centre.

• If there is an outbreak or case of a vaccine preventable disease (e.g., measles), children and staff who are not up-to-date with their immunizations may be excluded from the child care centre to minimize the risk of spreading the disease.

1.4 Tuberculosis (TB)

TB is a contagious disease caused by TB germs. TB usually attacks the lungs but can affect any other part of the body. It causes serious illness but is preventable, treatable, and curable with special antibiotics. About 300 people a year get sick with TB disease in Toronto.

TB transmission

TB is spread from person to person through the air. TB is spread when someone sick with TB of the lungs coughs or sneezes the germs into the air. It is not highly contagious. Close, prolonged or regular contact with someone who is sick with TB disease is needed to spread this disease.

TB infection

Most people who breathe in TB germs are able to stop them from growing. The immune system traps the TB germs and keeps them inactive. This is called TB infection. A person with TB infection:

• Will have a positive skin test
• Does not feel sick/has no signs and symptoms
• Cannot spread TB germs
• Can go to work

TB infection can be treated with preventive medication which will reduce the risk of developing TB disease later in life.

TB disease

TB germs become active when the body’s immune system is unable to stop the germs from growing. The active TB germs then begin to grow and cause damage to the body. Symptoms of TB disease are:

• Cough (lasting longer than 2 weeks)
• Fever/chills/night sweats
• Feeling tired/unexplained weight loss/loss of appetite
• If the TB disease is in a part of the body other than the lungs, the symptoms will depend on where the TB is growing. An example would be a swollen lymph node or joint pain.
• A person with infectious TB disease cannot go to work until a doctor confirms that this person cannot spread TB germs to others. People with TB disease must complete treatment to cure the disease.
1.4.1 Recommendations for TB screening of staff and volunteers in day nurseries

Daycare/nursery school staff and volunteers need TB skin testing to protect themselves, other staff, volunteers and children. Toronto Public Health highly recommends that all staff and volunteers provide documentation of TB testing prior to employment. The TB skin test should be done anytime within 6 months before the start of employment.

1.4.2 TB testing recommendations for staff and volunteers prior to employment

1. If a new staff/volunteer does not know their TB status or has had a negative TB skin test result in the past, a single TB skin test is highly recommended.
   - If the TB skin test is negative - no further testing is needed at this time. (People with serious medical conditions that weaken the immune system, such as HIV or cancer, may have a negative skin test even though they are infected with TB. If you are in this category please speak to your doctor).
   - If the TB skin test is positive - a medical examination and chest x-ray is recommended. Sputum may also be collected. The physician should provide documentation that the individual with a positive TB skin test is free of TB disease before beginning work.

2. If a new staff/volunteer has had a documented previous positive skin test, the skin test does not need to be repeated – it will always remain positive. However, a medical examination and chest x-ray is recommended to ensure that daycare/nursery school staff and volunteers do not have TB disease. The physician should provide documentation that the individual with a previous positive TB skin test is free of TB disease before beginning work.

3. Any staff/volunteer who has a positive TB skin test should be aware of the signs and symptoms of active TB disease (i.e. cough lasting longer than 2 weeks, fever, chills, night sweats, loss of appetite, unexplained weight loss). Early diagnosis and treatment of TB disease is critical. If your skin test is positive and you develop signs and symptoms of active TB, see a doctor immediately.

Where to go for TB skin testing

A TB skin test can be done by your family physician, a walk-in clinic or at a neighborhood community health centre. For employment purposes, you generally will have to pay for the TB skin test.

1.4.3 Recommendations regarding annual TB skin tests or chest x-rays for staff/volunteers

Staffs/volunteers are not required to have annual or periodic skin tests or chest x-rays for TB. Repeat testing is required only if there is an infectious case of TB in the
daycare/nursery school. Should this occur, follow-up of the TB case and contacts will be coordinated by Toronto Public Health. Skin testing will be free if you are identified as a contact of a TB case.

**TB testing requirement for ECE students prior to their placement**

Some daycare/nursery schools participate in Early Childhood Education (ECE) field placements. Many ECE programs require their students to have TB screening. If you have ECE students, confirm that they have documentation from their physician that they do not have active TB disease (i.e. negative TB skin test [TST], or if TST positive then well and CXR shows no TB disease) prior to starting their placement.

1.4.4 **TB testing recommendation for children**

Routine TB testing for children is not recommended.

If you have questions regarding TB, contact TPH's Tuberculosis program at (416) 338-7600 (or e-mail us at targettb@toronto.ca).

Additional information about TB screening guidelines can be found at http://www.toronto.ca/health/tb_prevention (see Screening Recommendations).

*TB medicines are free when a doctor orders them from Toronto Public Health. TB is preventable, treatable and curable!*

**2.0 Environmental Health Expectations**

**2.1 Administrative Health Policies and Procedures**

**Background**

Policies and procedures assist child care centres in ensuring that staff are aware and trained on the specifics of their work activities in safeguarding the health and safety of children. In general, a policy sets out general rules or guidance on a specific matter (describes who, what, and why), but does not detail how to perform certain tasks. A procedure describes the step-by-step instructions for tasks that should be done in order to fulfill a policy.

**Expectations**

In general, policies and procedures must:

- Be practical to implement
- Be reviewed and updated annually, or as necessary, to incorporate best practices and encourage compliance
- Follow a standardized template
- Be linked to an educational program so that users understand and practice
- Be written to serve as a resource for providers responsible for their implementation (PIDAC, 2012)
• Be relevant to the setting
• Be accessible to all staff

Child care centres can use professional practice guidelines and standards, such as this guidance document, and regulatory requirements and standards when developing their policies and procedures.

### 2.1.1 Required Administrative Health Policies and Procedures

#### A. Management and Reporting of Communicable Diseases and Exclusion of Ill Children and Staff

##### I. Management and Reporting of Communicable Diseases Policy & Procedure:
This policy and procedure relates directly to how a child care centre responds to, manages, and reports communicable diseases. At a minimum, the following components must be included in the policy and procedure:
- Management of critical data and information (e.g., immunization records)
- Surveillance for signs and symptoms of infections
- Methods and contact information for reporting communicable diseases to Toronto Public Health (TPH)
- Reference to Exclusion Policy and Procedure and the Communicable Disease Reporting info sheet

##### II. Exclusion Policy and Procedure:
This policy and procedure relates to what steps a child care centre will take to exclude ill children and/or staff. At a minimum, the following components must be included in the policy and procedure:
- Signs and symptoms of communicable diseases
- Exclusion criteria (e.g., illness that prevents child from participating in activities; greater need for care than the staff can provide; illness poses a serious health risk if it spreads to others)
- A designated room or area for isolating ill children

#### B. Infection Prevention and Control (IPAC) Policies and Procedures
Each child care centre is required to develop, maintain, and implement policies and procedures for each applicable component of the IPAC program. Examples of such policies and procedures include, but are not limited to:
- Communication with parents and staff with respect to IPAC practices
- Diapering and toileting program
- Environmental cleaning and disinfection program
- Hand hygiene program
- Health evaluation of children for signs and symptoms of communicable disease
- Immunization requirements
• Laundering program
• Pest control program
• Handling of pets and visiting animals
• Prevention of occupationally acquired infections, including disease surveillance and management
• Toy cleaning and disinfection program

C. Outbreak Management
Each child care centre is required to develop, maintain, and implement a policy and procedure on Outbreak Management (for details on Outbreak Management, refer to section 3 of this document). At a minimum, the following components must be included in the policy and procedure:

• Notifying parents or emergency contacts to pick-up ill children as soon as possible
• Isolating ill children and staff until they can be taken home
• Preparing a line list of ill children and staff by recording name(s), date(s) of birth, gender(s), individual symptoms, the date and time children and staff became ill, and their room number or type (e.g., infant room or toddler room)
• Contacting TPH to report the outbreak by calling the Communicable Diseases Surveillance Unit (CDSU) at 416-392-7411
• Obtaining permission from parents to submit specimen samples to the Public Health Laboratory
• Contacting ill staff and the parents of ill children who were at home during the time before the outbreak was declared, to inform them of the outbreak and to determine if they are experiencing the same signs and symptoms (to add to line list)
• Enhancing environmental cleaning and disinfection procedures

Surveillance
Communicable disease surveillance includes:
• Observing children for illness upon arrival
• Recording symptoms of illness
• Recording attendances and absences
• Recording any outings, special events, etc.

The key to identifying an outbreak is the maintenance of good surveillance information.

Staff must monitor for an increase from baseline incidence of illness among staff and children. Baseline incidence is the normal level of illness in a given place and time.
2.2 Infection Prevention and Control Measures

When implementing IPAC measures, child care centre staff must conduct a risk assessment for all activities. As mentioned in section 2.1, policies and procedures for IPAC measures must be in written form and easily accessible to all staff.

**Risk Assessment**

With respect to IPAC measures, when performing activities and providing care, staff must assess the risk of:

- a. Contamination of skin or clothing by microorganisms in the environment
- b. Exposure to blood, body fluids, secretions, excretions, body tissues
- c. Exposure to non-intact skin
- d. Exposure to mucous membranes
- e. Exposure to contaminated equipment or surfaces
- f. Signs and symptoms of infection
2.2.1 Respiratory Etiquette
Staff must reinforce with children, other staff, and visitors the personal practices that help prevent the spread of microorganisms that cause respiratory infections. These infections spread most easily in settings where people are in close contact.

These personal practices include:
- Not attending the child care centre when acutely ill with a respiratory infection
- Minimizing contact with respiratory droplets when coughing or sneezing, including:
  - Turning the head away from others (e.g. "sneeze into the sleeve" and "cover your cough")
  - Maintaining a two-metre separation from others, when possible
  - Covering the nose and mouth with tissue
  - Immediate disposal of tissues into waste after use
- Practice hand hygiene

2.2.2 Hand Hygiene
Background
Every person has two categories of microorganisms on their skin, sometimes called transient and resident bacteria.
- **Transient bacteria** colonize the upper layers of the skin and are acquired from direct contact with children, staff, contaminated objects and/or the environment. Transient bacteria may also be easily passed on to others or from objects in the environment (also called fomites) and are a frequent cause of infections (WHO, 2009). Effective hand hygiene kills or removes transient bacteria on the skin and reduces the risk of transmitting communicable diseases to others.
- **Resident bacteria** are found in the deeper layers of skin and are more resistant to removal. These bacteria do not generally cause infections and can be beneficial to maintaining healthy skin.

Hand hygiene refers to any hand-cleaning action and is an integral part of Routine Practices. Several studies demonstrate that hand washing in child care centres significantly reduces diarrhoeal and respiratory illness (Huskins 2000, Ejemot 2008). Hand hygiene involves the removal or destruction of visible soil and transient microorganisms from the hands while maintaining good skin integrity. Intact skin is the body’s first line of defence against bacteria; therefore careful attention to skin care is essential. The presence of dermatitis, cracks, cuts or abrasions can trap bacteria and compromise hand hygiene. Dermatitis also increases shedding of skin and, therefore, shedding of bacteria.

There are two methods of killing/removing microorganisms on hands:
- **Hand sanitizing with alcohol-based hand rubs (ABHR) containing 70% to 90% alcohol is the preferred method when hands are not visibly soiled.** Using easily accessible ABHR in most settings takes less time than traditional hand washing. Use of ABHR is also more effective than washing the hands with soap and water when hands are not visibly soiled (note: providing an ABHR
product that contains an emollient (moisturizer) can significantly decrease "irritant contact dermatitis" under frequent-use conditions).

b. **Hand washing with soap and running water must be performed when hands are visibly soiled.** The presence of organic material can reduce the effectiveness of alcohol in ABHR. The mechanical action of washing, rinsing and drying is the most important contributor to the removal of transient bacteria. If hands are visibly soiled and running water is not available, use a moistened towelette to remove the visible soil, followed by ABHR.

A common barrier to hand hygiene compliance is the adverse effect(s) of products on the skin. Educating staff on the benefits of ABHR will help to alleviate anxiety and promote its use (PIDAC, 2014). ABHRs have been shown to be less irritating to skin than soap and water despite perceptions to the contrary. If an individual feels a burning sensation following the application of ABHR, it is generally due to pre-irritated skin. Allergic-contact dermatitis associated with ABHRs is uncommon. Non-alcohol-based waterless antiseptic agents are not recommended for hand hygiene in healthcare settings and must not be used (PIDAC, 2014).

**Expectations**
Child care centres must establish a hand hygiene program consisting of the following minimum elements:

- Children are taught proper hand hygiene by staff/caregivers
- Staff/caregivers should teach and must supervise children using ABHR and ensure ABHR is used when hands are not visibly soiled
- Hand washing must be carried out when hands are visibly soiled (use of ABHR is not appropriate when hands are visibly soiled)
- Staff, visitors, parents and children must clean hands upon arrival and/or entry into any room
- Staff must clean hands:
  - Before initial contact with children or handling items in the room
  - Before and after glove use
  - After toileting
  - Before preparing, handling or serving food or giving medication
  - After treatment/care involving blood, body fluids, secretions and excretions of children or staff, even if gloves were worn
  - Before and after handling pets
  - After coming in from outside
  - After dispensing/handling expressed breast milk
  - Whenever in doubt
- Staff should assist children with cleaning hands:
  - After playing outdoors
  - After using the washroom
  - Before eating
  - Before and after handling pets
  - When sneezing, coughing, etc.
  - Before and after communal sensory play activities
Whenever in doubt
• Every room must be provided with at least one designated hand wash sink adhering to the following:
  o Hand Hygiene information sheets must be posted at every designated hand wash sink
  o Hot and cold running water must be provided
  o Liquid soap in a dispenser and paper towels must be provided

Child care centres must have written policies and procedures for the established hand hygiene program. The policies and procedures must include:
• When to perform hand hygiene
• How to perform hand hygiene
• Selection of products used for hand hygiene
• Management of product dispensing containers
• How hand hygiene compliance will be monitored and feedback given

2.2.3 Glove Use

Background
Gloves are an excellent barrier device for reducing the risk of communicable disease transmission. Improper glove use, including re-using gloves, has been linked to transmission of pathogens such as methicillin-resistant Staphylococcus aureus (MRSA) and gram-negative bacilli (Poutanen et al., 2005). As well, gloves are not completely free of leaks and hands may become contaminated when removing gloves. Therefore, it is important to ensure gloves are worn and removed properly to reduce the risk of disease transmission. Studies show that IPAC interventions, such as glove use, can result in decreased gastrointestinal illnesses in childcare settings (Krilov et al., 1996).

Note: Note that the use of gloves does not replace the need for hand hygiene.

Expectations
• Gloves must be worn when it is anticipated that hands will be in contact with mucous membranes, broken skin, tissue, blood, body fluids, secretions, excretions, or contaminated equipment and environmental surfaces.
• Gloves must be appropriate for the type of activity and single-use only.
• Hand hygiene must be practiced before putting on and after taking off gloves.
• Gloves must be removed immediately and discarded into a waste receptacle after each use.
2.2.4 Diapering and Toileting

**Background**
Diapering and toileting can pose a risk of communicable disease transmission. Many healthy newborns and infants are colonized by the enteric pathogen *Clostridium difficile*, which may not cause disease in children, but it may affect older children and adults who are susceptible to severe diarrhea and colitis. The organism is acquired in infancy from environmental contamination in the child care centre or home environment. Studies indicate that hands become heavily contaminated with microorganisms during routine neonatal care (Pessoa-Silva et al., 2004), which highlights the importance of hand washing during and after the diaper change routine.

**Expectations**
The following elements are necessary in order to prevent the spread and control of diseases while diapering:
1. A designated diaper changing area with a suitable diaper change table/mat
2. A separate and designated hand wash sink within the diaper changing area
3. Single-use disposable gloves
4. Separate diapers and ointments/creams for each child
5. A suitable disinfectant
6. Garbage disposal unit(s)

The separate hand wash sink in the diaper changing area must only be used staff and children for the purpose of washing hands after diapering and toileting. The diaper changing area must always be separate from the food preparation area. In addition, the use of gloves, as a barrier to the transmission of communicable diseases, is required during the diaper change routine.

Although the toileting routine differs from the diaper change routine, the risks and successful IPAC interventions are the same. As such, hand washing sinks, disinfectants, and gloves are required during the toileting procedure as well.

**Note:** To reduce hand irritation related to gloves:
- Wear gloves for as short a time as possible
- Clean and dry hands before putting on gloves
- Use gloves that are clean and dry

Use appropriate gloves (e.g. rubber gloves) when handling chemical agents.
2.2.5 Expressed Breast Milk

Background
Expressed breast milk (EBM) is a body fluid and may contain microorganisms from the mother or from outside sources (such as contamination during pouring). Improper handling of EBM may result in contamination with microorganisms that can cause infections such as MRSA, Group B streptococcus, *Klebsiella pneumoniae* and *Pseudomonas* species (PIDAC, 2012). Since EBM is not sterile, these microorganisms can multiply if it is not handled properly (Cossey et al., 2011).

Safe handling, thawing, storage and administration are required to minimize the risk of infection to children and staff. It is important to ensure proper temperature control and handling of EBM. Feeding the incorrect EBM to an infant or child can lead to disease transmission, so labelling containers is important to avoid unintended consumption.

Expectations
- Apply Routine Practices when handling EBM
- Frozen EBM must be thawed in a refrigerator and used within 24 hours. Do not use a microwave to thaw EBM
- Keep EBM refrigerated at a temperature of 4°C Celsius or colder, until used
- Ensure bottles and containers are properly labelled (date, name of infant/child and name of mother)
- Clean hands before and after handling EBM
- Wear gloves while handling EBM (e.g. dispensing into a cup or from a container)
- Supervise children drinking EBM from a cup to prevent unintended consumption by other children
- Discard any left over EBM not consumed by the child
- Contact TPH immediately if another child consumes EBM intended for someone else (PIDAC, 2012).
2.2.6 Environmental Cleaning and Disinfecting

Background
Increased rates of childhood infections are influenced by the physical environment. A study by Laborde et al. (1993) found that faucet handles were among the most contaminated sites in child care centres. For example, Rotavirus (a virus that causes severe diarrhoeal disease in infants and young children) can live for extended periods of time on surfaces and objects such as doorknobs. Widespread contamination of environmental surfaces with viruses that can cause gastrointestinal illness has been found in child care centres, especially in rooms with diaper-aged children.

Cleaning is the physical removal of foreign material (e.g. dust, soil, etc.) and organic material (e.g. blood, secretions, excretions, microorganisms, etc.). Cleaning physically removes rather than kills microorganisms. Cleaning is accomplished with warm water, detergent(s) and mechanical action. After cleaning an object, it is necessary to rinse with clean water to ensure detergent film is removed.

Disinfection, a process completed after cleaning, is the process of killing most disease-causing microorganisms on objects using chemical solutions.

Expectations
Child care centres must implement a comprehensive environmental cleaning and disinfection program. The program must include:

- Written policies and procedures
- Written schedule(s) that identify areas and items to be cleaned and disinfected, frequencies of cleaning and disinfection (i.e. daily, weekly and monthly), and the person(s) doing the cleaning and disinfection
- Information relating to the cleaner(s) and disinfectant(s) used at the child care centre

Environmental Cleaning and Disinfecting Policies and Procedures
The applicable policies and procedures shall include:

- Who is responsible for the cleaning and disinfection
- What products are to be used on various surfaces
- How and when the product is to be used (staff should be able to provide a description of the products used, contact times, proper dispensing and usage, including during an outbreak)
- Procedures for cleaning and disinfection during an outbreak
- Cleaning and disinfection standards and frequency
- An appendix with the cleaning and disinfection schedule(s) appropriate for each room
2.2.6.1 Choosing a Cleaner
The ease of cleaning is an important consideration in the choice of materials used in your centre (PIDAC, 2012). When choosing a cleaner, consider the following:

- Finishes, furnishings and equipment in your facility
- Compatibility with disinfectants used in the centre

2.2.6.1.1 Using a Cleaner
Cleaning must be done as soon as possible after contamination. When using cleaning products, do not apply by aerosol or trigger spray (PIDAC, 2012a). It is important that the sequence or steps involved in the cleaning process be done in the correct order:

- Wear the appropriate personal protective equipment for the task
- Clean in a progression from low-touch to high-touch surfaces and from top to bottom
- If required, rinse surface(s) with clean warm water

2.2.6.2 Choosing a Disinfectant
Using a ready-to-use/pre-mixed disinfectant is ideal compared to mixing chemicals on site. The chosen product must: be labeled as a disinfectant; have a Drug Identification Number (DIN #); a Material Safety Data Sheet (MSDS); a predetermined shelf-life; a recommended and short contact time; and an efficacy statement (PIDAC, 2012a).

**Note:** Products containing phenols must not be used in child care centres because they can cause Hyperbilirubinemia (jaundice) if not rinsed properly.

**An ideal disinfectant should...**

- Have a broad spectrum of antimicrobial effectiveness
- Be fast acting (e.g. disinfectant should have a rapid and realistic contact time)
- Not be affected by environmental factors (e.g. disinfectant remains active in the presence of different soils or contaminants; doesn’t react negatively with other cleaning products)
- Have good cleaning properties (e.g. remains active in the presence of organic matter and doesn’t react negatively with other cleaning products)
- Be non-toxic or non-irritating at in-use concentrations
- Carry wide material compatibility (e.g. wood, leather, etc.)
- Be easy to use with clear label instructions
- Be economical or cost effective in-use
- Be stable in concentrate or use-dilution and therefore have a suitably long shelf life
2.2.6.2.1 Using a Disinfectant

- Read and follow all manufacturer instructions before use
- Wear appropriate personal protective equipment
- Cleaning is a critical step before disinfection. Ensure there is substantial reduction in bio-burden by manually scrubbing with a combination of detergents and warm water before disinfection or use an approved One-Step Disinfectant Cleaner
- Use a test reagent (e.g. test strip) to test the concentration of disinfectant solutions and discard and replace when necessary
- Consider the type of microorganisms that can potentially be present on the surface to be treated (e.g. is the surface exposed to blood, skin, etc?)
- Choose the appropriate disinfectant (i.e. type and concentration) of chemical required for disinfection (e.g. disinfection of a blood spill requires a higher concentration of disinfectant than disinfection of toys)
- The disinfectant must be mixed daily in a clean bottle. Never top up disinfectants (PIDAC, 2012a)
- Each disinfectant bottle must be appropriately labelled
- Do not dip a soiled cloth into the disinfectant solution (no ‘double-dipping’)

2.2.6.3 Surface Types

2.2.6.3.1 High-touch Surfaces

High-touch surfaces may include doorknobs, toys, cribs/cots, light switches and computer keyboards that are touched frequently. These surfaces require frequent cleaning and disinfection. For these surfaces, cleaning and disinfection is required at least daily and more frequently if the risk of contamination is higher (e.g. during an outbreak).

2.2.6.3.2 Low-touch Surfaces

Low-touch surfaces may include floors, walls and windowsills that are touched less frequently. These surfaces require cleaning and disinfection as needed.

2.2.6.3.3 Other

- Carpeted floors can be more heavily contaminated for prolonged periods than non-carpeted floors and can be a potential source of microorganisms during outbreaks of norovirus (PIDAC, 2012). Carpets must be vacuumed as necessary, cleaned promptly if a spill occurs, and shampooed/steam cleaned every 3-6 months. If the carpet does not appear to be adequately cleaned, re-cleaning may be necessary or replacement must be considered.
- Floor mats that cannot be adequately cleaned and disinfected should be promptly removed and replaced.
- Refer to TPH "Blood and Body Fluids" infosheet for cleaning blood or body fluids
- Label individual toothpaste tubes and store separately. If many children are using toothpaste from the same tube, the toothpaste must be dispensed onto paper towel and then applied to the brush.
2.2.7 Sleep equipment

Background
Children may be scheduled for sleeping periods at child care centres as part of regular day routines. It is important to ensure this activity is carried out in a sanitary manner.

Expectations
- Sleep equipment must be labelled and assigned to a single child.
- Sleep equipment must be cleaned and disinfected before being assigned to another child.
- Crib mattresses must be made of a cleanable material.
- Crib mattresses must be cleaned and disinfected when soiled or wet.
- Sleeping mats must be stored so as to avoid contact with the sleeping surface of another mat.
- Bedding (sheets and blankets) must be assigned to each child and laundered weekly, when soiled or wet.

2.2.8 Toys

Background
Toys and play-based learning are an integral part of a childcare program. Toys and sensory play are excellent methods by which to enhance children’s sense of touch, sight, taste, smell and hearing. However, toys are also excellent vehicles for the spread of disease-causing microorganisms.

Expectations
The following expectations are necessary to reduce the risk of disease transmission to children when playing with toys and sensory play materials:
- Children must practice hand hygiene before and after playing with toys.
- Playrooms must be provided with both ABHR and a designated hand wash station.
- Toys must be maintained in good repair and must be inspected for damage to avoid compromising cleaning and disinfection and discarded if necessary.
- Toys purchased for use in child care centres must be easy to clean and be able to withstand frequent cleaning and disinfection.
- Toys used for water-play must not retain water as they can provide an environment for bacterial/mould growth.
- Toys that are mouthed or contaminated by body fluids must be cleaned and then disinfected before handling by another child.
- Homemade playdough, due to its high moisture content, is more likely than store-bought playdough to harbour and allow the growth of microorganisms. Thus, used homemade playdough must be discarded daily. Unused homemade playdough must be stored in the refrigerator for up to one week. Store-bought playdough must be discarded according to manufacturer's recommendations.
- Sensory play bins and tubs that contain dry materials must be cleaned and disinfected after they are dumped and before replenishing.
• **Water play** bins/tubs must be drained, cleaned and disinfected after each session. **Note:** choose water play bins/tubs that are easy to move, drain, clean and disinfect.

• **Toy storage boxes/cupboards** must be emptied, cleaned and disinfected as necessary. Toy bins must be monitored for pest activity.

• **Playhouses/climbers** must have their high-touch surfaces cleaned on a daily basis. A thorough cleaning of the entire playhouse/climber must be done according to a regular schedule based on frequency of use and when visibly soiled.

• **Shared electronic games, video equipment and computers** must be cleaned and disinfected between users. Computer keyboards must be either submergible, have a cover, or be made of a material that can be cleaned and disinfected.

The following sensory play materials are not recommended:

- Sand, gravel, and other materials obtained from outdoor locations
- Meat trays, or soiled egg cartons and toilet paper rolls
- Manure or other products containing possible fecal matter or chemicals

Similar to environmental cleaning and disinfection, child care centres must implement a comprehensive toy cleaning and disinfection program. The program must include:

- Written policies and procedures
- Written schedule(s) that identify toys to be cleaned/disinfected, frequencies of cleaning/disinfection (i.e. daily, weekly and monthly), and the person(s) doing the cleaning/disinfection.
- Toy cleaning and disinfection schedules should be posted. The frequency of cleaning and disinfection varies depending on the age group and the amount of handling of toys:
  - **Infant (under 18 months):** Frequently touched toys in infant rooms must be cleaned and disinfected daily (or more often as necessary)
  - **Toddler (18 – 30 months) & Preschool (>30 months – 5 years):** Frequently touched toys in toddler and preschooler rooms must be cleaned and disinfected weekly (or more often as necessary)
  - **Kindergarten & School Age (5 – 12 years):** Frequently touched toys in the school aged rooms must be cleaned and disinfected monthly (or more often as necessary)

**Expectations for Toy Cleaning and Disinfection**

- Wear appropriate personal protective equipment (e.g. rubber gloves).
- Toys must be cleaned and rinsed prior to disinfection.
- Ensure that the disinfectant being used is safe and suitable for the intended purpose and that the manufacturer’s directions for dilution and contact times are followed.
- Ideally toys must be cleaned and disinfected using the 3-compartment sink method or a dishwasher. The 2-compartment sink method is acceptable if washing and rinsing are done in the first sink. If no sinks are available then the 3-bin method is acceptable.
2.2.9 Laundry

Background

Bedding materials and improper laundering of bedding materials used in child care centres may increase the risk of communicable disease transmission. Although sheets and cot covers can harbour microorganisms that grow well in a moist and warm environment, if handled appropriately transmission of infections is rare (PIDAC, 2012).

Expectations

The following expectations are necessary to reduce the risks associated with improper laundering of bedding materials from laundering:

- Develop a policy and procedure which includes the collection, transport, handling, washing, and drying of soiled items
- Children’s soiled clothing must be sent home for cleaning (do not rinse; roll and place items in a sealed plastic bag; solid stools must be disposed of in the toilet prior to bagging clothes)
- Soiled items must be kept separate from clean items in a covered container/bag
- Bedding (sheets and blankets) must be assigned to each child and laundered weekly or when soiled or wet
- Laundry must be done in a separate space from the kitchen. Existing child care centres that launder in a kitchen area must ensure laundry is done at alternate times to food preparation. Surfaces must be cleaned and disinfected prior to food preparation/after laundering.

Note: For grand-parented premises with a domestic dishwasher, follow proper disinfection methods (choice of: a minimum of 82°C during the rinse cycle; using a solution that provides a detergent/sanitizer mixture; or after dishwashing, soak items in a disinfectant solution for required contact time).

For new or renovating premises, Toronto Public Health requires commercial dishwashers to be installed in order to comply with the Ontario Food Premises Regulations, 562 (1990).

Note: For new or renovating premises, Toronto Public Health requires laundering facilities to be separate from any food preparation area. There must also be a utility sink installed in the laundry area.
2.2.10 Pest Control

**Background**
Pests such as mice, rats and cockroaches pose a potential health risk as they are known to carry disease and can trigger or worsen asthma symptoms in individuals. Every child care centre must implement and follow an Integrated Pest Management (IPM) program. IPM consists of a multi-pronged approach which focuses on pest prevention. Core principles of IPM involve eliminating pests' access to food, water and shelter (College of Agricultural Sciences, 2015).

**Expectations**
- Child care centre operators and staff are responsible for ensuring their centre is pest free.
- Child care centre staff must follow the IPM principles of eliminating pests' access to food, water and shelter, which must include, at a minimum:
  - Cleaning all rooms (especially food preparation areas), closets, cupboards and storage areas regularly
  - Inspecting the exterior structure of the building. Eliminate pest access into the building by repairing/replacing screens or by plugging holes, cracks and other entryways
  - Addressing problems to structural issues inside the facility
  - Ensuring clutter and accumulation is reduced inside and outside the facility to eliminate places where rodents/vermin can live
  - Ensuring food and sensory play materials (e.g. dried pasta) are stored in labelled plastic containers with tight fitting lids
  - Monitoring for pest activity such as live or dead rodents/vermin and/or their faeces
  - Child care centre operators must notify/consult their pest control operator if any pest activity is observed in the premises (may be provided by the landlord such as a School Board, or professional licensed company)

2.2.11 Pets and Animals

**Background**
Contact with animals can provide a valuable learning opportunity for children. However, bringing animals and children together has potential risks. These risks include allergies, injuries and infections (CDC, 2014). Young children, particularly those less than 5 years of age, are more likely to develop serious illness from infections due to microorganisms such as *Salmonella* and *E. coli 0157:H7*. Animals such as reptiles and amphibians are known carriers of *Salmonella* while tropical birds are known carriers of the disease psittacosis (CDC, 2014; NASPHVACC, 2013).

**Expectations**
In order to prevent injury or illness to staff and children in child care centres, the expectations listed below must be followed:
- Child care centre staff and children may have contact with the following animals: dogs, cats, rabbits, birds, rodents (e.g. mice, hamsters, rats, gerbils, guinea pigs) and fish. These animals must have an appropriate temperament to be around
children and show no signs of disease.

- Dogs and cats shall be fully immunized against rabies, must be trained and be in good health. Dogs and cats must also be on a flea, tick and intestinal parasite control program. They must be up-to-date with applicable vaccinations and medication. Written proof from a veterinarian is required.
- Pet birds (e.g. budgies, parakeets) are strongly discouraged in child care centres.
- The following animals are **prohibited** to be kept as pets and are not recommended to be involved in activities with children such as visits to the child care centre:
  - Exotic animals (e.g. hedgehogs, monkeys)
  - Wild/stray animals (e.g. bats, raccoons, stray dogs or cats, squirrels)
  - Inherently dangerous animals (e.g. lions, cougars, bears)
  - Venomous or toxin-producing spiders and insects
- The following animals are **prohibited** to be kept as pets and are not allowed to visit the child care centre, including indoor/outdoor travelling animal shows for children <5 years of age:
  - Reptiles (e.g. turtles, snakes and lizards)
  - Amphibians (e.g. frogs, toads, newts and salamanders)
  - Live poultry (e.g. chicks, ducklings and goslings)
  - Ferrets
  - Farm animals (e.g. calves, goats and sheep)

**Expectations for Pet Handling**
The following expectations are necessary to ensure a safe and sanitary environment is provided for children coming into contact with pets and/or animals:

- Child care centre operators and staff must be educated as to which animals are permitted.
- Child care centre staff must teach children on the humane and safe procedures to follow when in close proximity to animals.
- All children and staff who handle animals must practice strict hand hygiene after contact with animals, their feed, and/or their environment.
- Child care centre staff must supervise all contact between animals and children. Children must not feed the animals or have food or drink in proximity of the pets.
- Animals must be housed within some barrier (e.g. cage) that protects the children.
- Dogs or cats shall wear proper collars with a license tag (no choke chains as they harm little fingers).
- Animals are prohibited from entering a food preparation area.
- A staff member must be assigned to clean the pet habitat and wear personal protective equipment when doing so.
- Pet enclosures/cages and/or habitats must not be cleaned in food preparation sinks or areas.
- Cages must be placed in a well-ventilated area, cleaned regularly using a damp cloth and then disinfected.
- Animal bites shall be immediately reported to TPH.
2.2.12 Occupational Health and Safety

Occupational health and safety involves health and safety aspects in the workplace. The Ministry of Labour (MOL) directly oversees and enforces all matters relating to occupational health and safety. As such, the MOL employs two Infection Control Practitioners in order to review requirements and provide consultation on IPAC issues in the workplace. As a result, occasional audits of "Health Care Facilities" are conducted.

Although child care centres are not defined under the Health Care and Residential Facilities Regulation, the MOL has set precedent by applying this regulation to work settings where IPAC is a key component of that work setting.

Additionally, the Health Protection and Promotion Act (HPPA), as well as sections of the Ontario Public Health Standards requires local public health units to investigate and alert the MOL with respect to occupational health hazards (HPPA, R.S.O. 1990, c. H.7, s. 11 [1]). It is the responsibility of local public health units to keep informed of matters relating to occupational health and safety (HPPA, R.S.O. 1990, c. H.7, s. 12 [1]).

In order to comply with occupational health and safety legislation, activities in the child care centre may require the use of personal protective equipment (PPE) (e.g. gloves, mask, eye protection, safety boots). Examples of activities that may require the use of PPE include handling hazardous chemicals such as those used for making your daily disinfection solutions. It is important to note that IPAC measures will also ensure compliance with occupational health and safety legislation (e.g. wearing gloves during diaper change). As well, it is important to ensure chemicals are stored out of reach from children and separate from food.

When using PPE, remember:
- PPE should be appropriate for the type of activity (e.g. rubber gloves for cleaning and disinfection versus medical-type gloves for diaper change)
- Always follow manufacturer’s instructions for PPE
- Ensure appropriate PPE is available for use by staff depending on the activities in the child care centre

3.0 Management of Outbreaks

All child care centres must develop and maintain written policies and procedures in preparation for responding to infectious disease outbreaks, including but not limited to gastroenteritis outbreaks. Toronto Public Health will review these written policies and procedures on an annual basis during your routine inspection. Please refer to the section 2.1.1 (C) on what to include in an Outbreak Management Policy and Procedure.

3.1 Public Health Response

Once a suspect outbreak is reported, TPH will assist with the coordination and management of the outbreak. If an outbreak is declared, you will be working closely with two TPH staff to manage your outbreak:
• A Public Health Inspector from Healthy Environments will assist you with your environmental control measures for gastrointestinal illness outbreaks (e.g. review cleaning/disinfection procedures, outbreak consult, on-site inspections).

• A Communicable Disease Investigator from Control of Infectious Diseases & Infection Control (CID/IC) will assist in case management for gastrointestinal and respiratory illness outbreaks (e.g. review line lists, provide exclusion letters, facilitate stool kit submission to the Ontario Public Health Lab and declare the outbreak over).

### 3.2 Identifying an Outbreak

A suspect outbreak exists when there is an increase in the baseline incidence indicating there is a higher than expected number of children and staff who are experiencing similar symptoms of illness. To determine whether a suspect outbreak exists:

- Review your surveillance data, communication books or daily log
- Identify similar symptoms of illness in children/staff
- Check recent child/staff absenteeism records
- Review and eliminate other possible reasons for symptoms (new medications or diet changes)

For example, if there are two or more people with the same symptoms, same room, same day; then call TPH to consult. To report a suspect outbreak call the Communicable Diseases Surveillance Unit (CDSU) at 416-392-7411. Have the following information ready when you call:

- Date and time of the first case
- Date and time of the most recent case
- Total number of children and staff per room
- Total number of ill children and staff per room
- Signs or complaints of symptoms of illness (e.g., diarrhea, vomiting, fever)
- The control measures that you have implemented to date

To help keep this task as easy as possible, TPH can provide you with a form to collect this initial information (Outbreak Line-Listing Form).

TPH staff (CID/IC) will then review the information you provide and determine whether or not an outbreak must be declared. As an example, an enteric outbreak may be declared where a child care centre experiences above the baseline (normal) incidence of illness in children and/or staff with one or more of the following gastrointestinal symptoms: diarrhea, vomiting, nausea, abdominal cramps, chills and/or fever. Early detection and timely implementation of outbreak control measures can effectively minimize disease transmission, thereby more effectively controlling an outbreak. When an outbreak is declared you will receive an Outbreak Number that must be written on your documentation (e.g. line list, stool kit submission forms).

### 3.3 Child Care Centre’s Role in Outbreak Control

All child care centres are legally responsible for reporting outbreaks to their local public health unit. Once the outbreak has been reported, the child care centre is required to:
Follow all TPH recommendations and expectations
Provide TPH with the necessary information pertaining to children and staff
Facilitate the collection of stool specimens (after obtaining consent from a parent)
Immediately report changes associated with the outbreak and provide updated information about the outbreak on a daily basis using the TPH Outbreak Line List
Communicate necessary information to the families of children attending the centre. TPH will provide you with a letter for parents once an outbreak has been declared.

3.4 Establishing a Case Definition
A case definition will be established in order to define who is included as a case in an outbreak investigation. A case definition defines a case in time, person and place (i.e., the date of onset of symptoms of the first case, the symptoms experienced and the age group or room that is affected). An example of a case definition would be: all children and staff of ABC child care centre with symptom onset of watery diarrhea and fever starting July 1, 2012.

By creating a case definition, public health professionals are better equipped to study an outbreak and determine possible causes. As investigations proceed, this definition may be expanded or narrowed. This is characteristic of the dynamic nature of outbreak investigations. The case definition must be established in consultation with TPH staff.

3.5 Line List
The line list is a tool that allows TPH to evaluate the extent of the outbreak. Its purpose is to monitor the number of new cases that occur each day. Only new cases that fit the case definition must be added to the line list (e.g. no person must be on the list who does not have or previously had symptoms outlined in the case definition and persons must not be listed more than once). There must be a separate line list for children and staff. The following will help with establishing and maintaining your line lists:

- Line lists must be updated daily and forwarded to TPH by noon each day or another mutually agreed upon time
- Provide an updated list even if there are no new cases
- Advise TPH of any hospitalizations or deaths of line-listed cases (staff and/or children) Note: this is a rare occurrence but one that must be brought to the attention of TPH
- Encourage older children to report any outbreak-related symptoms to their caregiver

3.6 Investigating a Possible Source of an Outbreak
Viral gastroenteritis most often appears as sudden onset of very loose watery diarrhea and/or vomiting. The illness is most often spread via person to person. Usually there is quick resolution of symptoms (within 24-48 hours). Viruses can also be transmitted through food or on items that are soiled with vomit or stool. Until proven otherwise, food is always assumed to be the source of an enteric outbreak. TPH staff often conducts food and child care centre inspections to ensure proper infection control measures are instituted to reduce the risk of transmission.
3.7 Sampling
Specimen sampling will occur at the discretion of TPH in consultation with the child care centre staff. Stool specimens may be required if there is a high proportion of ill children and/or staff, or the symptoms are severe. CID/IC TPH staff will provide instructions at time of investigation.

If an organism is identified in one specimen and only one specimen was submitted, then permission from the parent to release the results must be obtained prior to releasing the results to the child care centre operator. If an organism is identified where multiple specimens were submitted, the child care centre may be informed of the results such as the organism (e.g., norovirus) but not case's identity.

Parents/guardians of children must be notified if samples are going to be collected from their child and consent must be received prior to submission to Central Public Health Laboratory (CPHL) for testing. In the event that an opportunity to collect a specimen presents itself prior to notifying the parents/guardians, the specimen can be collected but must not be sent to the lab until parental consent has been received. Results from lab specimens will always be released to the parent/guardian.

3.8 Initial and Additional Control Measures
The child care centre operator must communicate to all child care centre staff/volunteers/parents what control measures have been implemented as a result of the Outbreak Management consult. Additionally, the child care centre operator is responsible for coordinating and ensuring that the agreed upon control measures are enforced.

Ill children and staff are to be excluded from the child care centre. Note: As a minimum children and staff can return to the child care centre when they have been symptom-free of vomiting and/or diarrhea for 48 hours (or until other disease specific criteria has been met such as two negative stools taken 24 hours apart). TPH staff will give updated directions regarding exclusion as required.

Children who become ill while attending the child care centre must be isolated from other children until a parent or guardian can take them home. Ill staff must report all outbreak related illness to their Supervisor. All ill staff must be advised that they are not to work at another child care centre until they have met the criteria established by TPH.

Additional control measures include, but are not limited to:
- Reviewing and reinforcing hand hygiene practices, while providing all rooms with adequate supplies
- Increasing the frequency of cleaning and disinfecting of common areas, high touch surfaces and toys
- Adjusting the concentration of disinfectant that is approved for use against the organism circulating during the outbreak (most likely norovirus)
- Suspending communal activities such as sensory play or baking activities
- Reinforcing with staff, children and visitors the importance of keeping hands clean
• New admissions can continue if the parent/guardian is aware of the outbreak and understands potential risks (as outlined by TPH)
• Visits by outside groups (e.g. entertainers, facility tours, etc.) are not permitted during an outbreak
• Child care centre operators must limit the movement of staff and children from room to room as much as possible
• Wearing PPE. Child care centre operators and staff must use gloves where indicated (e.g. diapering, cleaning, spills)
• Toilet and diaper routine must be reviewed, including the proper use of gloves
• Increasing (one or all) frequency, concentration or contact time of disinfectant
• Ensuring change table is disinfected after each use (with an appropriate disinfectant) and infant/toddlers hands are washed. Refer to the TPH Information Sheet “Choosing and Using a Disinfectant” or “Bleach Solutions for Disinfecting” for details regarding the strength of disinfecting solution to be used during outbreaks.

3.9 Communication with Parents
TPH will provide a letter to advise all parents of the outbreak and what actions are necessary should their child become symptomatic. The child care centre supervisor(s) must communicate all control measures to parents/guardians.

3.10 Declaring the Outbreak Over
The outbreak will be declared over when the child care centre is clear of new cases that meet the case definition for the period of communicability of the causative agent plus the incubation period.

Where no organism is isolated see tables below, the length of time from last case until outbreak is declared over is based on the case definition and/or established.

Toronto Public Health will inform the child care centre when the outbreak has been declared over and provide recommendations to prevent future outbreak.
### 4.0 Guidelines for Common Communicable Diseases Child Care Centre Resources

#### Non Reportable Critters

<table>
<thead>
<tr>
<th>Critters</th>
<th>Signs &amp; Symptoms</th>
<th>Transmission</th>
<th>Infectious Period</th>
<th>Exclude?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Head Lice</strong></td>
<td>Itchy scalp, nits (whitish-grey egg shells) attached to hair shafts, live lice.</td>
<td>Contact: Direct contact head-to-head (live lice). Indirect contact by sharing hats, hair brushes, headphones, etc.</td>
<td>While nits or lice are present.</td>
<td>No - Children with head lice can attend school/day care and should be treated. Children should avoid close head-to-head contact.</td>
</tr>
<tr>
<td><strong>Pinworms</strong></td>
<td>Itching around the anus, disturbed sleep and irritability.</td>
<td>Contact: Direct contact from fingers contaminated from scratching. Indirect contact from contaminated bed linens, clothing, toys, etc.</td>
<td>Until treatment is completed.</td>
<td>No - Re-infection from contaminated hands is common, therefore reinforce hand washing.</td>
</tr>
<tr>
<td><strong>Scabies</strong></td>
<td>Red, very itchy rash which usually appears between fingers, on palms, underarms, wrists, soles, elbows, head and neck. Itchiness is usually worse at night.</td>
<td>Contact: Direct contact from person-to-person, prolonged, close and intimate skin-to-skin contact. Mites are almost invisible to the naked eye.</td>
<td>Until treated, usually after 1 or 2 courses of treatment, a week apart.</td>
<td>Yes - Exclude until after 24 hours of the first treatment given.</td>
</tr>
</tbody>
</table>
## Non Reportable Diseases

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Signs &amp; Symptoms</th>
<th>Transmission</th>
<th>Infectious Period</th>
<th>Exclude?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common Cold</strong> <em>(Rhinoviruses)</em></td>
<td>Runny nose, sneezing, sore throat, cough, fever, headache, decrease of appetite and lack of energy. Most colds last for 7 to 10 days.</td>
<td>Droplet: From cough and sneeze of an infected person to a distance of &lt; 2 meters. <strong>Contact:</strong> Direct contact with respiratory secretions. <strong>Indirect contact</strong> with toys, other objects or surfaces contaminated with respiratory secretions.</td>
<td>Highest during the first 2 to 3 days of symptoms and until 7 to 10 days after onset of symptoms.</td>
<td>No</td>
<td>If child feels well enough to participate</td>
</tr>
<tr>
<td><strong>Hand, Foot &amp; Mouth Disease</strong> <em>(nonpolio enteroviruses)</em></td>
<td>Fever, loss of appetite, malaise, sore throat, small painful mouth ulcers and a rash (small red spots or blisters on hands, feet and in mouth) and headache. May last 7 to 10 days.</td>
<td><strong>Contact:</strong> Direct contact with stool, saliva, nose and throat secretions or fluid from the blisters of an infected person. <strong>Indirect contact</strong> with contaminated toys, objects or surfaces.</td>
<td>For duration of illness and up to several weeks after onset of illness.</td>
<td>No</td>
<td>If child feels well enough to participate</td>
</tr>
<tr>
<td><strong>Impetigo</strong> <em>(Streptococcus pyogenes or Staphylococcus aureus)</em></td>
<td>Cluster of red bumps or fluid-filled blisters, which may ooze a clear fluid or become covered by an itchy honey-coloured crust. Usually appears around a child's mouth, nose or on exposed skin of the face or limbs.</td>
<td><strong>Contact:</strong> Direct contact with skin lesions. <strong>Indirect contact</strong> with contaminated bed linens or clothing.</td>
<td>From onset of rash until 1 day after start of treatment.</td>
<td>Yes</td>
<td>Until 24 hours after treatment has been initiated. Lesions on exposed skin should be covered.</td>
</tr>
</tbody>
</table>
## Non Reportable Diseases (continued)

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Signs &amp; Symptoms</th>
<th>Transmission</th>
<th>Infectious Period</th>
<th>Exclude?</th>
</tr>
</thead>
</table>
| **Fifth Disease**  
Also known as "Slapped Cheek" erythema infectiosum  
(Parvovirus B19) | A very red rash on a child's cheeks (slapped face appearance). A red, lace-like rash develops on torso and arms, then over the rest of the body. Rash may itch occasionally. May have low-grade fever, malaise, or a mild cold before rash starts. Rash may last 1 to 3 weeks. | Contact: Direct contact with respiratory secretions. | Several days before the appearance of the rash. Not infectious once rash appears. | No - If child feels well enough to participate |
| **Conjunctivitis**  
Also known as Pink Eye  
**Bacterial**  
(nontypable Haemophilus influenzae and S. pneumoniae)  
**Viral**  
(adenoviruses) | Purulent: Pink or red eyeballs, white or yellow discharge, matted or red eyelids and eye pain. Usually caused by a bacterial infection.  
Non-Purulent: Pink or red eyeball, clear and watery discharge, mild or non pain. May be caused by virus or non-infectious condition. | Contact: Direct contact with eye secretions.  
Droplet: From coughs and sneezes of an infected person to a distance of < 2 meters. | Bacterial: Infectious until 24 hours of appropriate antibiotic treatment.  
Viral: Infectious as long as there is eye discharge. | Yes - Until assessed by their health care provider. For bacterial conjunctivitis exclude until 24 hours after appropriate antibiotics has started. |
### Non Reportable Diseases (continued)

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Signs &amp; Symptoms</th>
<th>Transmission</th>
<th>Infectious Period</th>
<th>Exclude?</th>
</tr>
</thead>
</table>
| **Ringworm** *(of the body)* Also known as **Tinea Corporis (various types of fungi)* | Itchy, flaky ring-shaped rash, on face, trunk, limbs, scalp, groin or feet. | **Contact:** Direct contact *(skin-to-skin).*  
**Indirect contact** sharing combs, unwashed clothes, shower or pool surfaces and under fingernails from scratching. Can also be acquired from pets. | As long as rash is untreated or uncovered. | Yes - Until the appropriate treatment has been started |
| **Scarlet Fever** *(Streptococcus pyogenes)* | Sore throat, fever, swollen tender neck glands with widespread bright red rash covering the entire body. Commonly seen on neck, chest, underarms, elbow, groin and inner thigh, tongue *(strawberry tongue).* Typically rash does not involve face, but there may be flushed checks. Rash feels like sandpaper. | **Contact:** Direct contact with saliva.  
**Droplet:** From coughs and sneezes of an infected person to a distance of < 2 meters. | Until 24 hours after appropriate antibiotic treatment started.  
In untreated cases, 10 to 21 days. | Yes - Until 24 hours after treatment has started and the child is able to participate in activities |
| **Strep Throat** *(Streptococcus pyogenes)* | Sore throat, fever and swollen tender neck glands. | | | |
### Reportable Diseases

<table>
<thead>
<tr>
<th>Disease</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Chickenpox</strong> (Varicella-Zoster virus)</td>
<td>Generalized, itchy rash: Crops of small red spots turn into fluid-filled blisters that crust as they resolve. Other systemic symptoms such as fever.</td>
<td><strong>Airborne</strong>: Spreads easily from person-to-person through the air (coughing/sneezing). <strong>Contact</strong>: Direct contact with the fluid from the blisters or respiratory secretions.</td>
<td>1 to 2 days before the rash develops, until crusting of all lesions (usually 5 days).</td>
<td>No - If child feels well enough to participate</td>
</tr>
<tr>
<td><strong>Norwalk</strong> (Norovirus)</td>
<td>Sudden onset of watery diarrhea, nausea, vomiting and abdominal cramps. Symptoms last from 24 to 60 hours.</td>
<td><strong>Contact</strong>: Direct contact with bodily fluids (contaminated hand to mouth). <strong>Indirect contact</strong> with contaminated food, water or other objects or surfaces contaminated with stool.</td>
<td>For duration of diarrhea.</td>
<td>Yes - 24 hrs symptom free Or 48 hrs symptom free during an outbreak.</td>
</tr>
<tr>
<td><strong>Measles</strong> Also known as Rubeola, Red Measles (Morbillivirus)</td>
<td>High fever, cough, runny nose, red eyes for 2 to 4 days before rash starts. Rash begins on face as small red spots, which enlarge and clump together and spreads down body.</td>
<td><strong>Airborne</strong>: Spread easily from person-to-person through the air (Highly contagious). <strong>Contact</strong>: Direct contact with respiratory secretions of an infected person.</td>
<td>3 to 5 days before onset of rash until 4 days after onset of rash.</td>
<td>Yes - Until 4 days after beginning of rash and when the child is able to participate.</td>
</tr>
</tbody>
</table>
### Reportable Diseases (continued)

<table>
<thead>
<tr>
<th>Disease</th>
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<tr>
<td><strong>Mumps</strong> (Rubulavirus)</td>
<td>Swollen and tender glands at the jaw line on one or both sides of the face. May include fever, malaise, headache, inflamed testes and respiratory symptoms (especially for children aged five and under).</td>
<td><strong>Droplet:</strong> From coughs and sneezes of an infected person to a distance of &lt; 2 metres. <strong>Contact:</strong> Direct contact with the saliva / respiratory secretions of an infected person.</td>
<td>7 days before to 9 days after onset of swelling.</td>
<td>Yes - Until 5 days after onset of parotid gland swelling</td>
</tr>
<tr>
<td><strong>Pertussis</strong></td>
<td>Usually begins with runny nose and cough. Cough progressively becomes frequent and severe and may result in a high-pitch whoop sound. Loss of breath or vomiting after coughing bouts may occur. May last 6 to 10 weeks.</td>
<td><strong>Droplet:</strong> From coughs and sneezes of an infected person to a distance of &lt; 2 metres.</td>
<td>Highly infectious in the early stages of runny nose and cough to 3 weeks after onset of whooping cough (paroxysms), if not treated. Or after 5 days of treatment.</td>
<td>Yes - Until 5 days of appropriate antibiotics have been completed. If untreated, until 21 days after onset of cough.</td>
</tr>
<tr>
<td><strong>Rubella</strong></td>
<td>Characterized by a red rash, low-grade fever and swelling of the glands in the neck and behind the ears. Usually uncomplicated illness in children.</td>
<td><strong>Droplet:</strong> From coughs and sneezes of an infected person to a distance of &lt; 2 metres. <strong>Contact:</strong> Direct contact with respiratory secretions of an infected person.</td>
<td>7 days before to 7 days after onset of rash.</td>
<td>Yes - For 7 days after onset of rash.</td>
</tr>
</tbody>
</table>
5.0 Glossary of Terms

**Additional Precautions (AP):** Precautions (Contact Precautions, Droplet Precautions, Airborne Precautions) that are necessary in addition to Routine Practices for certain pathogens or clinical presentations (e.g., respiratory symptoms). These precautions are based on how a disease-causing microorganism is transmitted (e.g., through direct contact, from droplets, airborne).

**Alcohol-based Hand Rub (ABHR):** A liquid, gel or foam formulation of alcohol (e.g., ethanol, isopropanol) which is used to reduce the number of microorganisms on hands in situations when the hands are not visibly soiled. ABHRs contain emollients to reduce skin irritation and are less time-consuming to use than washing with soap and water.

**Cleaning:** The physical removal of foreign material (e.g., dust, soil) and organic material (e.g., blood, secretions, excretions, microorganisms). Cleaning physically removes rather than kills microorganisms. Cleaning is accomplished with water, detergents and mechanical action.

**Communicable disease:** Illness caused by microorganisms that are transmitted from an infected person or animal to another person or animal.

**Communicable Disease Investigator:** a Public Health Inspector and/or Public Health Nurse who work in the Control of Infectious Diseases & Infection Control Program of TPH.

**Contamination:** The presence of an infectious agent on hands or on a surface such as clothes, gowns, gloves, bedding, toys, dressings or other inanimate objects.

**Child care centre:** means programs and services that,
(a) include the provision of child care, or
(b) are early years programs and services (defined as: programs and services for children or parents that are specified or meet the description set out in the regulations, which (i) involve or relate to the learning, development, health and well-being of children, (ii) do not provide child care and are not extended day programs, and (iii) are funded wholly or partly by the Ministry.

**Detergent:** A synthetic agent that can emulsify oil and suspend soil when cleaning.

**Disinfectant:** A product that is used on surfaces or medical equipment/devices which results in disinfection of the equipment/device. Disinfectants are applied only to inanimate objects. Some products combine a cleaner with a disinfectant. Disinfectants rapidly kill or inactivate most infectious agents. Disinfectants are only to be used to disinfect and should not be used as general cleaning agents, unless combined with a cleaning agent as a detergent-disinfectant. **Skin antiseptics should never be used as environmental disinfectants** (e.g., alcohol-based hand rub, chlorhexidine).

**Disinfection:** The inactivation of disease-producing microorganisms. Disinfection does not destroy bacterial spores. See also, **Disinfectant.**

**Drug Identification Number (DIN):** In Canada, disinfectants are regulated as drugs under the *Food and Drugs Act* and Regulations. Disinfectant manufacturers have to obtain a drug identification number (DIN) from Health Canada prior to marketing, which ensures that labelling and supporting data have been provided and that it has been established by the Therapeutic Products Directorate that the product is effective and safe for its intended use.

**Fomites:** Inanimate objects in the environment that may become contaminated with microorganisms and serve as vehicles of transmission.

**Hand Hygiene:** A general term referring to any action of hand cleaning. Hand hygiene relates to the removal of visible soil and removal or killing of transient microorganisms from the hands. Hand hygiene
may be accomplished using soap and running water or an alcohol-based hand rub (ABHR).

**Hand Washing:** The physical removal of microorganisms from the hands using soap (plain or antimicrobial) under running water

**HE Inspector:** Healthy Environments Public Health Inspector

**Incubation period:** The time elapsed from when a person is exposed to a disease-causing microorganism to when symptoms and signs of illness first appear.

**Infection:** The entry and multiplication of disease-causing microorganism in a host. Infected people may have clinical signs and symptoms of illness or have no symptoms (asymptomatic or sub-clinical infection).

**Infection Prevention and Control (IPAC):** Evidence-based practices and procedures that, when applied consistently, can prevent or reduce the risk of infection in clients/patients, care providers and visitors.

**Infectious Agent:** A microorganism, i.e., a bacterium, fungus, parasite, or virus, which is capable of invading body tissues, multiplying and causing infection.

**Low-Level Disinfection (LLD):** Level of disinfection required when processing equipment that is not invasive (e.g., diaper change pad) and some environmental surfaces. Equipment and surfaces should be thoroughly cleaned prior to low-level disinfection.

**Material Safety Data Sheet (MSDS):** A document that contains information on the potential hazards (health, fire, reactivity and environmental) and how to work safely with a chemical product. It also contains information on the use, storage, handling and emergency procedures all related to the hazards of the material. MSDSs are prepared by the supplier or manufacturer of the material.

**May:** indicates an advisory or optional statement.

**Must:** indicates best practice, i.e., the minimum standard based on current recommendations in the medical literature

**Personal Protective Equipment (PPE):** Clothing or equipment worn by staff for protection against hazards.

**Provincial Infectious Diseases Advisory Committee (PIDAC):** A multidisciplinary scientific advisory body which provides to the Chief Medical Officer of Health evidence-based advice regarding multiple aspects of infectious disease identification, prevention and control. More information is available at: [http://www.pidac.ca](http://www.pidac.ca).

**Respiratory Etiquette:** Personal practices that help prevent the spread of bacteria and viruses that cause acute respiratory infections (e.g., covering the mouth when coughing, care when disposing of tissues).

**Routine Practices:** The system of infection prevention and control practices recommended by the Public Health Agency of Canada to be used with all clients/patients/residents during all care to prevent and control transmission of microorganisms in all health care settings. These are also applicable to child care centre settings. For a full description of Routine Practices, refer to the Ministry of Health and Long-Term Care’s ‘Routine Practices and Additional Precautions for all Health Care Settings’. The Ministry’s Routine Practices fact sheet is available at: [http://www.health.gov.on.ca/english/providers/program/infectious/pidac/fact_sheet/fs_routine_010107.pdf](http://www.health.gov.on.ca/english/providers/program/infectious/pidac/fact_sheet/fs_routine_010107.pdf).

**Outbreak:** For the purposes of this document, an outbreak is an increase in the number of cases above the number normally occurring in a particular child care centre (i.e., greater than baseline) over a defined period of time.
**Precautions:** Interventions to reduce the risk of transmission of microorganisms (e.g. child-to-child, child-to-staff, staff-to-child, contact with the environment, contact with contaminated equipment).

**Shall:** indicates mandatory requirements based on legislated requirements (e.g., Child Care and Early Years Act) or national standards (e.g., Canadian Standards Association)

**Surveillance:** For the purposes of this document, surveillance is the systematic ongoing collection, collation and analysis of data about illness with timely dissemination of information to those who require it in order to take action. The actions usually relate to the prevention of further illness and/or control of an outbreak.

**TPH:** Toronto Public Health

**WHO:** World Health Organization
6.0 Works Cited


