



Guidelines for the Education Sector – Effective from 2nd May 2022

Preamble

This document highlights general public health principles intended for educational settings including childcare, kindergarten, primary, secondary, tertiary settings as of the Spring of 2022 thereby referred to as 'School/s' in this document. Each School should adapt these guidelines according to the specific setup of the School itself and in line with any other guidelines as issued from time to time by the Public Health authorities. Certain measures are applicable to specific educational settings only and this will be specific in the heading.

These guidelines are meant to mitigate, as much as possible, against the transmission of COVID-19 within the School setting. Although the risk of infection is reduced, it can never be completely eliminated. Policy makers, the educational sector, parents/guardians and students need to understand that a risk of transmission will still exist and even if these guidelines are rigorously followed and implemented.



SARS CoV-2 Transmission

The principle mode of transmission of SARS CoV-2 is through infected droplets passing from person to person when at a conversational distance either through inhalation (short range aerosol) of infected droplets or by deposition on the mucosa of eyes, nose or mouth (droplet). The virus can also spread in crowded or poorly ventilated indoor areas through airborne transmission. Persons may also become infected after touching surfaces which may have become contaminated and then touching eyes, nose and mouth. This risk is considered to be low.

The setting where the virus spread is more likely include crowded settings, close-contact settings and areas which are confined, with poor ventilation. Risk increases especially where these 3 Cs overlap¹

Symptomatology

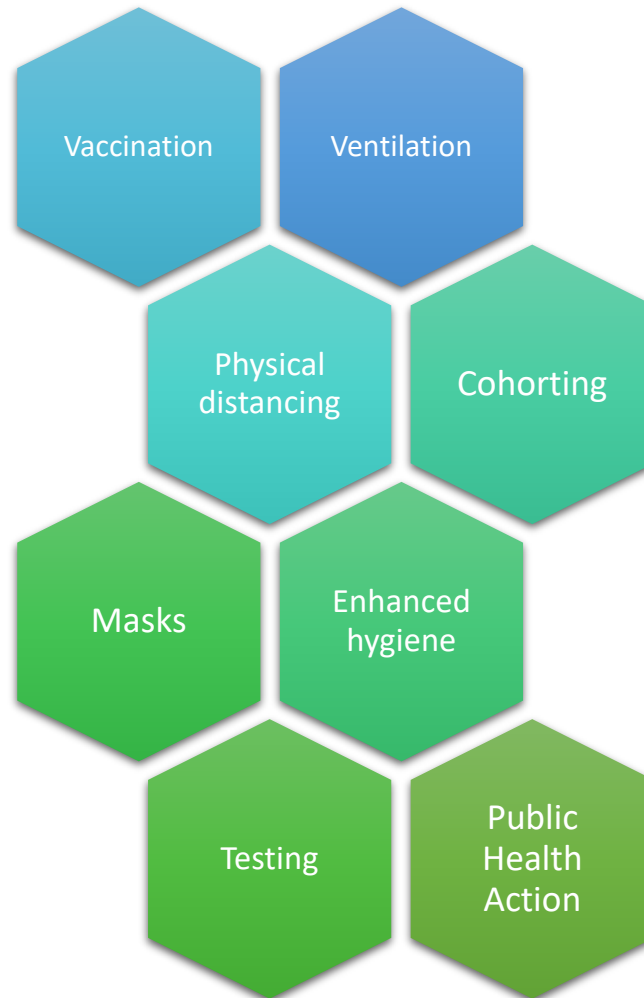
Symptoms of COVID-19 infection include one or more of the the following: headaches, runny nose or congestion, sore throat, sneezing, hoarse voice, persistent cough, muscle or joint aches and pains, chills and fever. Other symptoms include nausea, diarrhoea, abdominal pain, loss of sense of smell or taste².

¹ <https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted>

² Symptom prevalence, duration, and risk of hospital admission in individuals infected with SARS-CoV-2 during periods of omicron and delta variant dominance: a prospective observational study from the ZOE COVID Study. Cristina Menni*, Ana M Valdes* et al. The Lancet. 7th April 2022



Principles of Risk Mitigation



1. Vaccination

Persons administered a complete course of a COVID-19 vaccine have been shown to be highly protected from severe disease and death and this also protects from infection compared to the unvaccinated. This holds true for adults, adolescents and children. With time, immunity levels may wane, and the booster dose offered to adults increases and prolongs the protection from symptomatic infection particularly in light of the prevalent circulating variant Omicron (B1.1.529). Aggregate ECDC data has shown that although hospitalisation in children



is rare and risks from COVID-19 infection in children are higher among children with pre-existing medical problems- the majority of children who were notified to have been hospitalised had no pre-existing medical conditions of note.

Besides direct health effects on the individual, vaccination is considered to confer protection from disrupted learning and social disruption.

It is advised that all those persons eligible for vaccination should access this including the booster dose for adults.

2. Enhanced Hygiene Recommendations

Individual

- Parents/Students should assess for any signs of illness every morning before attending School. All persons who are unwell (students/staff) should not attend school
- Temperature screening of students/staff should be carried out at school entrance. A screening temperature $>37.2^{\circ}$ C or anybody who appears unwell should not be admitted into school
- If a staff member/ student appears unwell during school hours it is advisable that they return home
- Hand hygiene is important to avoid infection with SARS CoV-2 using soap and water or appropriate sanitisers. Younger children should be supervised when sanitising. Resources on hand washing can be accessed from <https://www.who.int/pmnch/covid-19/toolkits/child/wash/en/>
- Avoid touching mucous membranes such as eyes, nose and mouth
- Cover your coughs and sneezes carefully disposing of used tissues



- Procedures and personal protective equipment recommended for changing diapers in younger children and assisting students with disabilities should be observed (**Annex C**).
- A medical certificate to enable the child to return to school **after sickness** is required from a medical doctor (even if the child is sick for a single day). This certificate will provide the date when the child can resume in-person learning

Personal Belongings

- Discourage children from bringing unnecessary personal toys from home with the exception of those items required for educational purposes.
- Childcare/ Kindergarten - It is advisable that the toys/ educational materials used can be adequately easily cleaned especially when used by different groups of children.

Premises

- Premises and resources are to be cleaned daily using approved products. For further details regarding the methods and agents recommended kindly refer to **Annex B**.
- Common functional rooms and common resources used by different groups of students need to be cleaned appropriately at regular intervals and at the beginning and the end of each day.
- Attention must be paid to the more regular cleaning of high touch areas eg. Handles, switches, tables ideally several times a day
- Toilets must be cleaned regularly, at least three times a day with a log of the cleaning time kept. Paper towels are preferred to hand blowers to dry one's hands.
- Students/ staff should be encouraged to wipe down their desks and equipment with appropriate cleaning agent before and after use.
- Special considerations for using the correct cleaning agents or use of protective covers for the hardware in computer labs and shared resource rooms



- The risk of infection by touching an item which was previously touched by a person infected with COVID-19 is considered to be extremely small. The CDC³ quantifies this risk as less than 1 in 10,000. An emphasis on hand hygiene when handling books or papers touched by others is sufficient
- Entry of non-teaching personnel, parents and guardians should be regulated by the school management to ensure physical presence for essential purposes but for as long as is necessary in line with limiting social mixing and avoiding crowding in educational premises. All activities necessary for the medical, psychological, educational and structural safety of the educational community should take place.

3. Physical Distancing & Cohorting

- Unnecessary contact eg. Hugging, shaking hands and kissing between students, or between students and staff members should be avoided
- Persons should try to maintain an adequate physical distance from one another when interacting, where this is feasible.
- Where possible/feasible students and staff should remain within the same classroom/cluster/group whose composition remains constant
- It is understood that children may be unable to maintain an adequate physical distance from others (particularly in the childcare and kinder settings).
- The concept of cohorting helps to control excessive and unnecessary interactions. The limitation of the size of the cohort is what determines the size of the bubble and the number of potential interactions the child may have.
- Crowding of persons should be avoided and can be mitigated by staggering entrance and dismissal, encouraging orderly flow of students/staff in common areas.

³<https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/surface-transmission.html#ref7>



- Teaching and non-teaching staff should keep **2 metres** between themselves (between staff) and between staff and students.
- For Learning Support Educators to be able to provide the service required of them, they may need to work at close proximity to the students they are supporting. However, the distance may vary as it depends on the needs of the individual student
- ❖ Year 9 (Form 3) upwards where a good proportion of the age groups have been vaccinated, maximum efforts should be made to maintain a minimum distance of **1 metre** in all directions between students whilst sitting in their chairs (except if desk is placed near a wall).
- ❖ However, for children in Year 8 (Form 2) downwards where vaccination uptake is not yet optimal, maximal efforts should be made to maintain an adequate physical distance of **1.5 metres** between students in all directions whilst sitting in their chair (except if desk is placed near a wall).
- ❖ In the childcare and the kinder settings, it is understood that children may be unable to maintain an adequate physical distance from others although this should be encouraged.
- ❖ It is recommended that, if possible, staff attend the staff room at staggered times to avoid crowding together. Taking one's break outdoors is better than indoors, a ventilated indoor room is better than one which has no air circulation. If a system of 'hot desking' is in operation, each person should be responsible to clean the surfaces and shared electronics with suitable agents before and after use.
- All medical, educational and other activities deemed important and essential should take place keeping basic mitigation measures in mind - physical distancing, ventilation, masking in crowded indoor settings.



❖ Childcare Centres:

- In order to allow for better distancing, the COVID-19 Maximum Child Capacity per Childcare centre is based on 6 square metres per child instead of the 5 square metres per child set in the National Standards for Childcare facilities (2006).
- The number of children allowed to attend shall be subject to the available space and the number of available carers in accordance with the carer to child ratio as established in the National Standards
- In line with minimising social mixing, where feasible, children and carers must remain within the same cluster/group which composition remains constant. This applies to both children and staff.
- There should be no more than 6 supervised children per cluster/group⁴
- If possible, at nap time ensure adequate spacing between children. It would be a good practice to place them head to toe in order to further reduce the potential for viral spread.

❖ Kindergarten

Maximum efforts should be made to ensure that the total number of children as established in the calculation of distances should be capped at 15 children in Kinder 1 and 19 children in Kinder 2.

⁴ National Standards for child daycare facilities.

<https://tfal.org.mt/en/professionals/PublishingImages/Pages/Tools/Standards%20Child%20Day%20Care%20Facilities.pdf>



4. Ventilation

Outdoor lessons and activities are encouraged since this allows for additional ventilation and also better distancing between students. Any viral particles are easily diluted in the air as opposed to when one is within an enclosed space where cross-ventilation using open apertures and ventilation systems becomes more important for the circulation of air.

In indoor settings, regular and adequate ventilation is essential to reduce the level of possible pathogens in the air. Doors and/or windows should be kept open throughout the day to allow for cross ventilation. To improve ventilation, efforts should be made to keep windows open during lessons and also, at regular intervals such as mid-way through lessons, in-between lessons and during breaks prop windows even further open to force greater circulation of the air. If the ambient temperature is uncomfortable for the children during the winter months, they should be encouraged to wear more layers of clothing. If air-conditioning is to be used, this should be used in accordance with the guidelines issued by Public Health authorities⁵. Filters should always be cleaned well and maintained properly.

5. Masks

It will no longer be mandatory to wear a mask in schools. However, individuals are free to make their own assessment of risk for themselves and for their children given that evidence to date still shows that wearing a mask is an effective means of preventing viral spread to others in conjunction with maintaining an adequate physical distance from others.

As yet, there is no evidence that face shields are effective as source control or protection from respiratory droplets as masks thus, masks should be used.

⁵ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Guidance_Air-conditioning-and-ventilation-systems_23Jun20.pdf



Considerations for Specific Activities in Schools

All activities which used to take place pre- COVID-19 pandemic should take place keeping basic mitigation measures in mind. Those activities which involve increased physical contact eg. Sports or increased aerosol generation eg. Singing or playing wind instruments may be additionally mitigated by increasing distances between students, taking place outdoors or in well ventilated rooms.

Shared food is still discouraged in light of the continued viral spread. Any food provided in school should be individually portioned.

Gatherings

Gatherings involving the school community can take place in line with the general principles of cohorting and physical distancing as mentioned above. Schools are responsible to take the measures necessary to mitigate against any potential viral transmission.

School Transport

The following recommendations should be considered for school transport:

1. Increase the frequency of transport services
2. Keep journeys as short as possible
3. Retaining the same cohort/cluster of students on every journey. This is essential to allow for proper contact tracing



4. Keeping accurate records of all students on each trip including their seating positions
5. Keep vehicles well ventilated, keeping windows open and no air recirculation
6. Maintain safe physical distancing between students to decrease the number of occupants in the vehicle
7. Masks are not mandatory on transport however it is recommended for students and staff
8. Availability of sanitizers in the vehicle
9. Proper cleaning of the vehicle between journeys
10. Parents of students to take temperature of their children every morning before attending School. If there are signs of illness, the students should not go to school.

If a child is noticed to be sick whilst at school

- ✓ Plan to have an isolation room within the school or an area that can be used to isolate a sick child until the child is collected by the parent/guardian.
- ✓ Disinfect the rooms where the adult and/or child were sick.
- ✓ If a sick child has been isolated clean and disinfect surfaces in your isolation room or area after the sick child has gone home in line with the [Cleaning of Non-Hospital Premises Settings after confirmed COVID-19 cases](#)⁶.

⁶ <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Cleaning%20and%20disinfection%20of%20non-hospital%20settings%20after%20confirmed%20COVID-19%20positive%20case.pdf>

Annex A: Shielding

Shielding of Students

The need to shield children should be based on a discussion and in-depth assessment between the caring **hospital consultant paediatrician**, the child's parents and school management in particular circumstances on a case-by-case basis. As much as is possible, children who are deemed to require shielding should still be able to attend school physically and the benefit of attending school should be weighed with the need to keep children and young people with certain underlying conditions safe. Alternative arrangements and measures may be implemented by the school to allow the child to physically attend school. Moreover, this measure should not be used to increase truancy or absenteeism, particularly for the children who are most vulnerable (either for medical and/or social reasons).

Annex D contains an updated list of clinical conditions which are to be used to guide hospital consultant paediatricians for the assessment of children who may require shielding. The certificate does not divulge the illness or medical condition that the child is suffering from. Also, this protocol does not delve into the type or suitability of shielding as this needs to be determined between the caring physician, the parents and school. Hospital consultant paediatricians are to contact parents of children who may require shielding to determine whether a certificate should be issued. Parents who are in doubt or who have not been contacted by their hospital paediatrician, may consult their family doctor who in turn will advise the parents accordingly, in line with the list of conditions in Annex D.

Children living with household members who require shielding or are sick do not require shielding themselves and can/should attend school.



Shielding of Staff

The Legal Notice LN 111 of 2020 Protection of the Vulnerable was repealed on the 5th June 2020 and clinically vulnerable people are no longer required to stay at home. The principal measure to combat COVID-19 infection is ensuring that at the first available opportunity one takes the full course of an EMA approved COVID-19 vaccine which would have been made available to all students and staff in this setting. The vaccination roll out in Malta was such that medically vulnerable persons were prioritized for vaccination. Moreover, it has been announced that immunocompromised persons would be offered a second booster dose of a COVID-19 vaccine starting in April 2022. In light of the above measures, there is no specific group of persons who warrant blanket shielding.

Possible additional measures for shielding of students in schools

- Minimise contact with other children and staff
- Maintain interpersonal distances of greater than 2m
- Choosing a seating plan which would decrease exposure of the child to other children and staff
- Student may be advised to wear an N95 type mask
- Use of physical barriers such as Perspex
- More frequent hand washing and sanitizing
- Enhanced cleaning
- Use of private transport

For information regarding the shielding of employees please refer to Guidance for Offices and Workspaces⁷

⁷ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Guidance_For_Offices_And_Workspaces.pdf



Paediatric conditions that may necessitate shielding - September 2021⁸

The following are paediatric conditions for which children may be asked to shield. Advice to shield depends mainly on community transmission of SARS-CoV-2 and public health advice on when extremely vulnerable or less vulnerable people should shield. Degree of vulnerability is not the same for all conditions listed below, is also dependent on the severity of the condition and will be determined by the caring consultant.

Advice for shielding is also affected by:

- a) The Covid-19 vaccination status of the child
- b) the complexity of the underlying condition,
- c) guidance given by the caring hospital consultant,
- d) age of the child, and the mental capacity of the child with respect to the ability to perform hand hygiene, respect social distancing and put on and take off a face mask safely and
- e) the capacities of schools to provide help with shielding of vulnerable children: schools need to be well prepared for this and work to provide inclusive education to all children irrespective of any underlying condition the child might have. There should be no form of discrimination against children who suffer from a condition that makes them vulnerable.

Conditions that may put children more at risk* to COVID-19 are as follows:

****Not all children with these conditions have the same risk to COVID-19 and the need for shielding may vary depending on the epidemiology of SARS-CoV-2.***

⁸ Based on Covid-19 –shielding guidance for children and young people. RCPCH: 22nd September 2020

Immunodeficiency disorders

- Severe combined immunodeficiency, combined immunodeficiency which is severe or who have concurrent co-morbidity, HLH on active treatment, primary immunodeficiency disorders who need a transplant (up till 6 months post-transplant and as certified by their hospital consultant, children post bone marrow transplant with significant graft versus host disease on immunosuppressants, children being prepared for or after a solid organ or stem cell transplant as determined by their hospital consultant and children with Autoimmune polyendocrinopathy-candidiasis-ectodermal dystrophy (APECED). Concurrent co-morbidity means significant lung disease, renal impairment or chronic liver disease.
- HIV infection AND with a CD4 count less than 200 or had an opportunistic infection within the last 6 months or have detectable viral load or are not on any antiretroviral treatment.

Oncology

- Are on induction chemotherapy for Acute Lymphoblastic Leukaemia (ALL) or Non-Hodgkin's lymphoma or are on chemotherapy for Acute Myeloid Leukaemia (AML) or for relapsed and/or refractory leukaemia or lymphoma.
- Are post autograft transplant in the last 6 months or post allogeneic transplant within the last 12 months or until immune reconstituted.
- Are on CAR-T therapy or within 6 months from administration or until immune system has recovered.
- Are on chemotherapy for any cancer diagnosis or within 6 months of its completion or are on long term maintenance steroids.
- Have completed treatment for cancer but have ongoing significant respiratory, cardiac, renal or neurological conditions.

The majority of children in the following categories DO NOT need shielding but some may be asked to do so only if determined by their hospital consultant on a case-by-case basis.

Cardiology

- Fontan, single ventricle physiology, especially with evidence of failure, and or end organ damage.
- Persistent cyanosis (oxygen saturations <85% persistently)
- Pulmonary Arterial Hypertension (PAH) especially those on pulmonary vasodilator therapy.
- Severe and or symptomatic heart failure, particularly those on heart failure therapy.

Haematology

- Sickle cell disease with additional co-morbidities or with a history of at least one chest crises needing intensive care treatment or at least two chest crises necessitating treatment in the previous 12 months.
- Thalassaemia or other inherited or congenital anaemia with severe iron overload and additional co-morbidity.
- Asplenia or functional asplenia only if have other co-morbidities.

Neonatal

- Ex-premature infants with continuing oxygen and/or intermittent non-invasive ventilation requirements.
- Any infant who is eligible for palivizumab.

Neurology

- Patients with significant difficulty with swallowing (e.g. myotonic dystrophy patients).
- Patients at significant risk of decompensation during infection (e.g. mitochondrial disease).
- Patients with symptomatic heart failure, particularly those on heart failure therapy (e.g. Duchenne muscular dystrophy).
- Patients with myasthenic syndromes.



Gastroenterology, Hepatology & Nutrition

- Paediatric inflammatory bowel disease (IBD) patients with ANY of the following:
 - Whilst on intravenous or oral steroids ≥ 20 mg prednisolone (or >0.5 mg/kg) or equivalent per day.
 - Have started biologic therapy plus immunomodulatory or systemic steroids within previous six weeks.
 - Have moderate to severely active disease not controlled by moderate risk treatments who may require an increase in treatment.
- Intestinal failure patients requiring Home Parenteral Nutrition (HPN) with any of the following:
 - Primary immunodeficiency or immunodeficiency induced by drugs as part of their therapy.
 - Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
- Liver disease with any of the following:
 - Decompensated liver disease.
 - Receiving post-transplant immunosuppression or on liver/small intestine/multi-viscera; transplant waiting list.
 - Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
 - Active or frequently relapsing autoimmune liver disease where an increase in treatment is likely needed.

Renal

- Renal transplant especially if in the last 3 months.
- On a high level of immunosuppressive medication for active disease undergoing induction treatment: those who are currently receiving or completed treatment within 6 weeks of high dose steroids of 20 mg/day or above (or 30 mg/m² /day) AND cyclophosphamide or rituximab or other immunosuppressants.



Respiratory

- Have significant impairment in ability to cough and to clear airway secretions: including children with severe neurological diseases such as severe cerebral palsy, neuromuscular disabilities, severe motor impairment and severe metabolic disease.
- Require a cough assist device to help with clearance of airway secretions.
- Life-dependent on long term ventilation, both invasive (via tracheostomy) and non-invasive (CPAP and BiPAP).
- Severe lung disease requiring continuous or overnight supplementary home oxygen and/or intermittent non-invasive ventilation.
- Children with:
 - Cystic fibrosis and Primary ciliary dyskinesia.
 - Severe bronchiectasis.
 - Severe restrictive lung disease such as interstitial lung disease or obliterative bronchiolitis.
 - Severe asthma: children treated with biological agents or maintenance oral steroids.
 - Children with repaired congenital thoracic abnormalities such as congenital diaphragmatic hernia / trachea-oesophageal fistula only if significant airway or lung problem.

Down syndrome

Children with Down syndrome do not require shielding except if they have a co-morbid condition that falls in any of the criteria described above and as determined by their hospital consultant



Annex B: Cleaning

- ✓ In general, the infectivity of coronaviruses on inanimate surfaces (such as wood, metal, fabrics and plastic) decreases depending on the material and environmental conditions such as temperature, humidity and UV radiation. The cleaning of surfaces remains an important measure to ensure hygienic conditions.
- ✓ Premises and resources are to be cleaned daily using appropriate products. A combination of cleaning with soap and water and disinfection will be most effective in removing the COVID-19 virus. Both cleaning and disinfection is most effective, using a combination of household detergents and disinfectants. A detergent is designed to break up oil and grease with the use of water. Anything labelled as a detergent will work. Cleaning should start with the cleanest surface first, progressively moving towards the dirtiest surface. Change water regularly. When surfaces are cleaned, they should be left as dry as possible to reduce the risk of slips and falls, as well as spreading of viruses and bacteria through droplets. Disinfecting means using chemicals to kill germs on surfaces. It is important to clean before disinfecting because dirt and grime can reduce the ability of disinfectants to kill germs. Disinfectants containing $\geq 70\%$ alcohol, ammonium compounds, chlorine bleach or oxygen bleach are suitable for use on hard surfaces (surfaces where liquids pool, and do not soak in). The packaging or manufacturer's instructions will outline the correct way to use disinfectant. Disinfectants require time to be effective at killing viruses. If no time is specified, the disinfectant should be left for ten minutes before removing.
- ✓ Premises need to be cleaned thoroughly between one group/cluster of students and another.
- ✓ It is recommended that where possible soft flooring should be wiped down by detergents and washed properly at the end of each day.
- ✓ Attention to use appropriate products which are suitable for children <3years of age according to one's educational setting.



- ✓ Toilets must be cleaned regularly, at least three times a day. Toilet seats, fittings, wash basins and floors must be cleaned. In case of contamination with faeces, blood or vomit, disinfectant wipes should be used after removal of the contamination with a disposable cloth soaked in disinfectant.
- ✓ Protective gloves and mouth and nose protection must be worn by members of staff.
- ✓ A log detailing the time when the toilet facility has been cleaned and by whom should be filled in for each toilet facility. The use of disposable towelling in toilets is encouraged.
- ✓ The following areas should be cleaned particularly thoroughly and, if possible, several times a day in heavily frequented areas:
 - Door handles and any other handles on drawers, windows, etc.
 - Stairs and handrails,
 - Light switches,
 - Tables, phones,
 - and all other grip areas.

Childcare:

- ✓ Linen must be changed daily. The use of disposable towelling is encouraged.
- ✓ Use bedding (sheets, pillows, blankets, sleeping bags) that can be washed. Keep each child's bedding separate, and consider storing in individually labelled bins, cubbies, or bags. Cots and mats should be labelled for each child. Bedding that touches a child's skin should be cleaned at least weekly and certainly before use by another child.
- ✓ Common resources used by children require to be sanitised between one use and another and at the beginning and at the end of the day.
- ✓ Personal sanitising products for children are to be supplied by parents/guardians and are to be kept at the centre.
- ✓ Toys and other items need to be cleaned and sanitized regularly and certainly before another cluster/group uses these toys and items.



- ✓ Due to its heavy use as a play and exercise area for children, floor cleaning should be carried out more regularly and frequently throughout the day, and as necessary and as required in the case of spillages. Soft flooring should be wiped down by detergents in between use of different groups and washed properly at the end of each day.
- ✓ All areas to be cleaned will be checked by assigned personnel and will be documented and signed by means of a check list.

Guidance related to the cleaning measures to be undertaken after having one of more confirmed COVID-19 cases within the premises can be found on the public health website

⁹.

⁹ <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Cleaning%20and%20disinfection%20of%20non-hospital%20settings%20after%20confirmed%20COVID-19%20positive%20case.pdf>



Annex C: Students with a disability

Procedure for Changing nappies in younger children and students with disability

When changing the nappy of a student, the staff member must start by washing/ sanitising his/her hands together with those of the student. Disposable gloves must also be worn during this time. Follow safe diaper changing procedures and these should be illustrated using a procedures poster in all diaper changing areas.

Steps should include:

- Preparation (includes putting on gloves, mask **and** visor)¹⁰
- Cleaning of the student
- Removal and discarding of trash (soiled diaper and wipes)
- Replacing of a clean diaper
- Washing of student's hands
- Cleaning up and disinfection of the changing station
- Washing of hands

After changing nappies, the playworker/carer must wash his/her hands again (even if gloves were used) and the nappy changing area should be disinfected with a fragrance-free bleach as a sanitizing or disinfecting solution. If other products are used for sanitizing or disinfecting, they should also be fragrance-free. If the surface is dirty, it should be cleaned with detergent or soap and water prior to disinfection. Despite nappy changing being an activity where there

¹⁰ Important to use PPEs as recommended in view of the potential of handling of body fluids



is inherent contact, wearing appropriate PPEs would decrease one's risk of being identified as a high-risk contact.

Feeding, or Holding a Student with Disabilities

- Staff should wash their hands, neck, and anywhere touched by a student's secretions.
- Staff should change the student's clothes if these are soiled. They should replace their own overshirt or clothing, if there are secretions on it, and wash their hands again.
- Parents are to send a change or two of clothes every day.
- Contaminated clothes should be placed in a plastic bag.

Pools/Jacuzzi in Resource Centres

- Ensure that all staff and students attending the centre and the jacuzzi/pool session do not appear unwell or have any symptoms.
- Encourage all those who are eligible for vaccination and additional doses to accept these- this applies to students, educators and parents.
- Temperature screening on entrance to school/centre
- Minimise the number of staff members in contact with child to those necessary to support this child in the activity
- Ensure adequate ventilation of the premises- including circulating air by opening windows between sessions in line with previous sections of document



- Enhanced hygiene of premises in line with previous sections of document
- Use appropriate PPE for changing of students in line with other relevant sections of this document
- Regular routine swabbing of staff and students can be recommended