

Ministry of Health

COVID-19 Guidance: Acute Care

Version 6 – June 15, 2020

Highlight of changes

- Updated PPE requirements under active screening
- Added a section on Managing Visitors

This guidance document provides basic information and is not intended to take the place of medical advice, diagnosis, or treatment, legal advice or requirements. In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health or the Chief Medical Officer of Health, the order or directive prevails.

In particular, public hospitals and long-term care homes are required to adhere to all components of [Directive #5](#) on required precautions and procedures for health and safety and the use of personal protective equipment.

- Please check the Ministry of Health (MOH) [COVID-19 website](#) regularly for updates to this document, the case definition, testing guidance, and other COVID-19 related information.
- Please check the [Directives, Memorandums and Other Resources](#) page regularly for the most up to date directives.

Screening

Passive Screening

- [Signage](#) should be posted at all entrances and at triage areas which prompts health care workers (HCWs), volunteers, patients and any visitors to self-identify to a specific location or person if they experience COVID-19 symptoms.
- A list of COVID-19 symptoms, including atypical symptoms, can be found in the [COVID-19 Reference Document for Symptoms](#).

Active Screening

- All HCWs, volunteers, and staff should be aware of the early signs and symptoms of acute respiratory infection, such as fever, cough, or shortness of breath. Atypical symptoms should be considered as well, especially in children, older persons, and people living with a developmental disability.
- Acute care settings should instruct all HCWs, volunteers, and staff to [self-monitor](#) for COVID-19 symptoms at home and not come to work if feeling ill. Those who are experiencing symptoms should report this to the acute care setting.
- Acute care settings must conduct active screening for COVID-19 symptoms of anyone entering the facility. Staff should ideally be behind a barrier to protect from contact/droplet spread. A plexiglass barrier can protect staff from sneezing/coughing patients. If a plexiglass barrier is not available, staff should maintain a 2-metre distance from the patient. Screeners who do not have a barrier and cannot maintain a 2-metre distance should use Droplet and Contact Precautions. This includes the following PPE: gloves, isolation gown, a surgical/procedure mask, and eye protection (goggles or face shield).
- The [COVID-19 Patient Screening Guidance](#) document can be used as a tool to guide active screening activities and can be adapted as needed.
- Screening questions between a hospital emergency department and paramedic services should align to ensure consistency when transferring suspected or confirmed cases of COVID-19.

Positive Screening: What to do

- Provide the individual with a surgical/procedure mask and place them in a room with the door closed. Encourage them to practice respiratory etiquette, use tissues when needed with access to a waste receptacle, and provide them with alcohol-based hand rub.
- Measures should be taken to separate those who have screened positive for COVID-19 with those who have screened negative as much as possible. For example, those who have screened positive should avoid contact with others in common areas of the acute care setting (e.g., waiting rooms).

Reporting of Positive Screening

- COVID-19 is a designated disease of public health significance (O. Reg. 135/18) and thus reportable under the [Health Protection and Promotion Act](#).
- The acute care setting should contact their [local public health unit](#) to report a confirmed case of COVID-19.
- If the suspect COVID-19 case has been tested, with results pending, and the individual does not require hospital admission, please consult with the hospital Infection Prevention and Control Department and the local public health unit before the suspect case leaves the acute care setting.
- All laboratory results are reported to the ordering healthcare provider. Positive and indeterminate laboratory results will also be communicated through [routine processes](#) for reportable diseases in Ontario, which includes the [local public health unit](#).

Testing for COVID-19

Testing Guidance

- For guidance regarding which individuals should be tested, and recommended priority groups in cases of limited resources, acute care settings should follow the guidance outlined in the [COVID-19 Provincial Testing Guidance Update](#) document.
- For guidance regarding diagnosing and resolving cases, acute care settings should consult the [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#) document. This document also outlines the recommended approaches for HCWs who are returning to work after symptom resolution and/or COVID-19 testing.

Specimen Collection, Handling, and Submission

- Specimens should be sent to a [Public Health Ontario \(PHO\) Laboratory](#), or another suitable laboratory with testing capacity.
- A suspect COVID-19 case should be tested by collecting a single upper respiratory tract specimen. Upper respiratory tract specimens include a nasopharyngeal (NP) swab, deep nasal swab or a viral throat swab. When swabs are available, NP swabs are the preferred specimen, followed by a deep nasal

swab.

- NP swab collection is not considered an aerosol-generating medical procedure (AGMP) and therefore can be performed using Droplet and Contact Precautions (i.e., gloves, isolation gown, surgical/procedure mask, eye protection). Please see *Occupational Health & Safety* below for an overview of the different levels of precautions.

Outbreak Identification and Management

Outbreak Identification

The MOH has defined a COVID-19 outbreak in a public hospital as:

- Two or more laboratory-confirmed COVID-19 cases (patients and/or staff) within a specified area (unit/floor/service) within a 14-day period where both cases could have reasonably* acquired their infection in the hospital.

*Examples of reasonably having acquired infection in hospital include:

- No obvious source of infection outside of the hospital; OR
- Admitted for 5 or more days before symptom onset (based on the median incubation period of the virus)

Application of Outbreak Measures

- Respiratory infection outbreaks in institutions and public hospitals are a designated disease of public health significance (O. Reg. 135/18) and thus reportable under the [Health Protection and Promotion Act](#). The hospital should contact their [local public health unit](#) to report a suspected or confirmed outbreak of COVID-19.
- Outbreak control measures should be determined by the Outbreak Management Team in the acute care setting in consultation with the [local public health unit](#).
- In some instances, outbreak control measures beyond enhanced surveillance may not be required, even if the hospital meets the outbreak definition above. Some examples include:
 - The second case is a roommate of a known case and the second case has been appropriately maintained on Droplet and Contact Precautions since identification of the first case. In this example, there should be no ongoing transmission risk from the second case.

- Two cases among staff members who are close contacts of each other, and investigation suggests transmission is among the staff only, and there has been no transmission risk to patients from the staff cases.

Additional Considerations for a Single Confirmed Case

- One laboratory-confirmed case (patient or staff) who could reasonably have acquired their infection in hospital would not trigger the declaration of an outbreak. However, if the acute care setting confirms a single case which might be nosocomial, this should prompt a thorough investigation to obtain additional information and enhanced surveillance. Based on the case investigation, additional control measures could be warranted.
- Where a case involves staff considered likely to have been infected as a result of a workplace exposure, employers are reminded of their duty to notify the Ministry of Labour, Training and Skills Development, Joint Health and Safety Committee and labour union, as appropriate, for occupational illnesses (see below).
- Case investigations should address:
 - **Potential unidentified transmission:** In the period before the case was recognized, the case could have spread infection to others (e.g., case is a staff member who worked while pre-symptomatic or symptomatic without a mask for source control; case is a patient who wanders and interacts with others on the unit); or
 - **Potential unidentified sources:** No obvious source of infection in the specified area, which may indicate unrecognized transmission; or
 - **Additional transmission from source case:** If there is a possible source in the hospital and that source could have exposed others.

Declaring the Outbreak Over

- In consultation with the Outbreak Management Team and the local public health unit, the outbreak may be declared over when 14 days have passed, from:
 - There must be no evidence of ongoing transmission after the date when outbreak measures were implemented, AND
 - No unprotected exposures to patients/staff from patient or staff cases (e.g., date of isolation of last case in a patient; or, date of last shift at work in a staff member who worked during the period of

communicable with possible unprotected exposure(s) to patients/staff).

Managing Visitors

- In order to reduce the risk of COVID-19 transmission, consideration should be given to managing visitors. This should be accomplished through visitor policies that are based on balancing the need to mitigate risks to patients, staff and visitors, with the mental, physical and spiritual needs of patients for their quality of life.
- Existing visitor policies regarding essential visitors should be revised accordingly to allow visits by family/caregivers and other types of visitors.
- Acute care settings should continue to monitor COVID-19 activity in their facility and work closely with their local public health unit to understand COVID-19 activity in their community overall.
- Visitor policies should:
 - Be adaptive and flexible to:
 - Respond to the local COVID-19 situation.
 - The setting in which the policy is being applied.
 - The visitor's role.
 - Patient's circumstance.
 - Reinforce that public health measures (proper hand hygiene, respiratory etiquette, physical distancing, masking for source control) be followed.
 - Follow infection prevention and control practices in order to minimize the risk of COVID-19 transmission.
 - Support the ongoing provision of public education/communication on COVID-19 risks.
 - Be shared with and with patients, family/caregivers, other visitors and staff.

Occupational Health & Safety

Personal Protective Equipment (PPE)

- Acute care settings must follow the precautions outlined in [Directive #1 for Health Care Providers and Health Care Entities](#). Public hospitals must also follow the PPE requirements outlined in [Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007](#).

Summary of Required Precautions

Activity	HCW Precautions
Before every patient interaction	HCW must conduct a point-of-care risk assessment to determine health and safety measures required and will have access to the appropriate health and safety control measures, including an N95 respirator.
All interactions within 2 metres of suspected, presumed, or confirmed COVID-19 patients	All HCW or other employees who are within two metres of suspected, presumed or confirmed COVID-19 patients or residents shall have access to appropriate PPE. This will include access to: surgical/procedure masks, fit tested NIOSH-approved N-95 respirators or approved equivalent or better protection, gloves, face shields with side protection (or goggles) and appropriate isolation gowns.
All other interactions	At a minimum, Droplet and Contact precautions, must be used for all interactions with suspected, presumed, or confirmed COVID-19 patients or residents including: • Surgical/procedure mask • Isolation gown • Gloves • Eye protection (goggles/face shield)

Activity	HCW Precautions
Planned or Anticipated AGMP	Droplet, Contact, and Airborne Precautions, including: • N95 fit tested respirator, or approved or equivalent or better protection • Isolation gown • Gloves • Eye protection (goggles/face shield) Airborne infection isolation rooms (AIIR) should be used, if available. Negative pressure for AIIRs should be validated daily. If not available, a single room may be used with the door closed.

- Detailed precautions for HCWs, by activity and procedure, are listed in [PHO's Technical Brief on IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#). [Directive #5](#) includes a list of procedures that are considered to be AGMPs.
- Acute care settings should assess the availability of PPE and other infection prevention and control supplies that are used for the safe management of suspected and confirmed COVID-19 cases.
- HCWs who must wear PPE should be properly trained, at regular intervals, in the appropriate donning (putting on) and doffing (taking off) of PPE, with an emphasis on ensuring hands are clean before contact with their face. HCWs should also be trained in the care of and limitations of PPE.

Infection Prevention and Control

- The acute care setting should have written measures and procedures for worker safety, developed in consultation with the Joint Health and Safety Committee, including measures and procedures for infection prevention and control.
- Where possible, dedicated equipment should be provided for use in a room where a suspected or confirmed COVID-19 case is being cared for. At a minimum, dedicated equipment must be thoroughly cleaned/disinfected using an approved hospital-grade disinfectant prior to being used elsewhere. The disinfectant should have a Drug Identification Number (DIN) and the manufacturer's recommendations should be followed.
- Equipment used to clean and disinfect contaminated areas requires careful and

regular cleaning and disinfection to avoid inadvertent cross-transmission of microorganisms during subsequent use. When cleaning, particular attention should be paid to high-touch surfaces in both the patient areas and the common spaces (e.g., bed rails, remote control handles). Acute care settings should follow the environmental cleaning practices outlined in [PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd ed. document](#).

Staff Exposure/Staff Illness

- Staff, including HCWs, who test positive for COVID-19 should report their illness to their manager/supervisor or to Employee Health/Occupational Health and safety as per usual practice.
- In accordance with the [Occupational Health and Safety Act](#) and its regulations, an employer must provide written notice within four days of being advised that a worker has an occupational illness, including an occupationally-acquired infection, or if a claim has been made to the Workplace Safety and Insurance Board (WSIB) by or on behalf of, the worker with respect to an occupational illness or infection, to the:
 - Ministry of Labour, Training and Skills Development,
 - Joint Health and Safety Committee (or health and safety representative), and
 - Trade union, if any.
- Occupationally-acquired infections and illnesses are reportable to the WSIB.

Work Restrictions for HCWs

- For guidance regarding work restrictions and when to return to work, HCWs should refer to the [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#) document. The recommendations in the document take into account the HCW's symptoms or lack thereof, test results, and the staffing capacity of the facility.
- HCWs should also report to their Employee Health/Occupational Health and Safety department before returning to work.