Ministry of Health

COVID-19 Guidance: Acute Care

Version 8 – June 11, 2022

Highlight of changes

- Updates to screening guidance
- Removal of directives references
- Updated resource links
- Addition of statement on masking

This guidance document provides information for acute care, complex continuing care and rehabilitation hospitals to support their implementation of recommended infection prevention and control (IPAC) measures for COVID-19. It is not intended to take the place of medical advice, diagnosis, treatment, or legal advice. In the event of any conflict between this guidance document and any applicable legislation or emergency orders, or directives issued by the Minister of Health or the Chief Medical Officer of Health, the legislation, order or directive prevails.

Public hospitals can refer to Public Health Ontario's (PHO) technical brief Interim Infection Prevention and Control Measures based on COVID-19 Transmission Risks in Health Care Settings (publichealthontario.ca) which sets out precautions and procedures for health and safety. Please refer to PHO's technical brief Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 and MOH's guidance document COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities for information on the appropriate use of PPE.

Other resources

Ministry of Health:

- Please check the Ministry of Health (MOH) COVID-19 website and the Directives, Memoranda and Other Resources regularly for updates to this document, other COVID-19 related information.
- Management of Cases and Contacts in Ontario
- COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities

Public Health Ontario:

- Best Practices for Managing COVID-19 Outbreaks in Acute Care Settings
- Interim Guidance for Infection Prevention and Control of SARS-CoV-2 Variants of Concern for Health Care Settings
- Best Practices for Prevention, Surveillance and Infection Control Management of Novel Respiratory Infections in All Health Care Settings
- Best Practices for Infection Prevention and Control Programs in Ontario
- Interim Infection Prevention and Control Measures based on COVID-19 Transmission Risks in Health Care Settings (publichealthontario.ca)
- Cohorting Strategies to Facilitate Bed Flow in Acute Care Settings
- Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19
- Resources released by Ontario Health and/or supports from your local IPAC hub.

Active and Passive Screening

- The purpose of active and passive screening is to identify those who may be infectious to prevent potential spread of infection within the acute care facility.
- Passive screening means those entering the facility review screening questions themselves and there is no verification of screening (e.g., signage at entrances as a visual reminder to not enter if symptomatic).
- Active screening means there is some form of attestation/confirmation of screening. This can be achieved through pre-arrival submission of online screening or in-person. For example, this may occur at triage or at the clinic/unit registration desk for patients and visitors.
- Acute care facilities should refer to PHO's Technical Brief on Interim Infection Prevention and Control Measures based on COVID-19 Transmission Risks in Health Care Settings, for guidance on the use of active or passive screening for staff, visitors and patients and depending on the risk of transmission in their community.

- The use of active and passive screening for visitors and staff is at the discretion of the acute care setting leadership.
- Acute care settings should instruct all health care workers (HCWs), volunteers, and staff to self-monitor for COVID-19 symptoms and not come to work if feeling ill. Those who are experiencing symptoms should report this to the acute care setting.
- Acute care settings should have visitor policies that may include exemptions for visitors who fail screening (e.g., visitors of critically ill or palliative patients).

Masking

Please refer to the PHO technical brief documents: Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 and Interim Infection Prevention and Control Measures based on COVID-19 Transmission Risks in Health Care Settings and MOH's guidance document COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities for considerations of masking for visitors, patients and staff. Please refer to the Occupational Health and Safety section for more information on staff masking.

Outbreak Management

Declaring a confirmed outbreak:

- Two or more patients and/or staff within a specified area (unit/floor/service) with positive results from a polymerase chain reaction (PCR) test OR rapid molecular test OR rapid antigen test[1] within a 10-day period where both cases have reasonably acquired their infection in the acute care facility.
    - ✳ Examples of reasonably having acquired infection in acute care setting include:

[1] While positive rapid antigen test is sufficient for declaring an outbreak, use of molecular testing is preferred to rapid antigen testing for patients/staff.

  - Specific high-risk exposure to COVID-19 positive patient/staff or other high-risk exposure in the acute care facility; OR
  - Admitted for 5 or more days before symptom onset or positive COVID-19 test result (based on the median incubation period of the virus).
- One positive PCR or rapid molecular test in a patient or staff who could reasonably have acquired their infection in the acute care setting 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 may be warranted.
- In the context of **high community transmission** during a surge of COVID-19, staff cases should only be considered as having reasonably acquired their infection in the acute care setting if there was a known specific high-risk exposure (eg: PPE breach and/or unmasked interactions in break rooms with other staff) in the hospital. The above definition is for public health surveillance reporting purposes only. Application of outbreak management measures, particularly for staff-only outbreaks where there is no evidence of transmission to/among patients, are at the discretion of the Outbreak Management Team (OMT), with representation from the local PHU.

Outbreak Management

- Outbreak control measures (e.g., Infection Prevention and Control [IPAC] measures, use of appropriate PPE and/or operational changes) should be determined by the OMT in the acute care setting with representation from the local PHU.
  - When deciding whether or not to close the unit to admissions, the OMT should carefully weigh the competing risks of COVID-19 exposure on the outbreak unit with potential delays in access to care and risks of exposure to COVID-19 in other areas of the acute care setting.

- In some instances, outbreak control measures beyond enhanced surveillance may not be required, even if the acute care setting 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.
- Considerations for application of outbreak measures:
  - The use and frequency of point prevalence testing during times of high community transmission should consider the potential for incidental detection of COVID-19 among staff and patients, and ongoing screen testing that may already be occurring among staff.
  - Cohorting options should be designed to facilitate patient flow while managing risk of transmission and continuing to apply cohorting principles to both patients and staff. Please refer to PHOs document on Cohorting Strategies to Facilitate Patient Flow in Acute Care Settings for more information.
- Following the Management of Cases and Contacts in Ontario patients hospitalized due to COVID-19 related illness should isolate for 10 days from symptom onset, and patients with severe illness (requiring ICU level of care) should isolate for 20 days; however, isolation may be adjusted at the discretion of the acute care setting IPAC team. Essential caregivers can be accommodated on outbreak units as per local acute care setting policy and direction.
- Notification of patients who may have been exposed to a case in the acute care facility but are currently discharged from the facility is at the discretion of the acute care setting and/or the public health unit. Any further follow-up of the patient is at the discretion of the public health unit.

Declaring the Outbreak Over

- In consultation with the OMT and the local PHU the outbreak may be declared over when no reasonably acute care setting-acquired new patient or staff cases have occurred for 10 days. There should be:
  - No evidence of ongoing transmission AND
  - No high-risk exposures to patient/staff from patient or staff cases (e.g., date of last shift in a staff member who worked during the period of communicability with possible exposure(s) to patient/staff).

Other considerations

- Declaration of an outbreak (suspected or confirmed) is not required to implement enhanced measures at the discretion of the OMT or as directed by the local PHU (e.g., enhanced disease surveillance, infection prevention and control measures).
- Those eligible for molecular testing in acute care settings should only use molecular testing for diagnostic purposes. In some cases, rapid antigen tests (RATs) may be used to facilitate case, contact, and outbreak management. The results of a RAT may be used to declare a suspect or confirmed outbreak while awaiting confirmatory PCR or rapid molecular diagnostic test results.
- A negative RAT result should not be used independently to rule out COVID-19 in an outbreak situation due to the sensitivity of RATs and the increased pre-test probability of COVID-19 in the current epidemiological context.
- If a RAT is used in a person with symptoms or high-risk exposure (e.g., to expedite outbreak management), PCR or rapid molecular diagnostic (e.g., ID NOW) testing should also be performed in parallel.
  - Staff and/or patients are to be managed as a case if they test positive on a RAT or managed as a high-risk contact if they have symptoms and an epidemiological link until PCR or rapid molecular diagnostic test results are received. For more information please refer to Management of Cases and Contacts in Ontario . Additional information can be found in the following resources:

- Ministry of Health
  - Management of Cases and Contacts of COVID-19 in Ontario
  - COVID-19 Provincial Testing Guidance (gov.on.ca)

Occupational Health & Safety

Staff Exposure/Staff Illness

- Staff who test positive for COVID-19 should report their illness to their manager/supervisor and/or to the Occupational Health designate as per usual practice.
  - The manager/supervisor or Occupational Health designate must promptly inform the Infection Control Practitioner or designate of any cases or clusters of staff, including contract staff who are absent from work.

Reporting Staff Illness

- In accordance with the *Occupational Health and Safety Act (OHSA)* and its regulations, if an employer is advised that a current or former worker has an occupational illness or if a claim has been filed to the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker with respect to an occupational illness , the employer must provide written notice within four days to :
  - A Director appointed under the OHSA of the Ministry of Labour, Training and Skills Development (MLTSD),
  - The workplace's Joint Health and Safety Committee and
  - The worker's trade union, if any.
- This may include providing notice for an infection that is acquired in the workplace.
- The employer does not need to determine where a case was acquired and proof of a positive COVID-19 test is not required. If the employer is informed of an occupational illness, the case must be reported.
- In accordance with the WSIA, the employer must also report any instance of an occupationally acquired disease to the WSIB within 72 hours of receiving notification of said illness. For more information, please contact the MLTSD:
  - Employment Standards Information Centre: Toll-free: 1-800-531-5551

- Health and Safety Contact Centre: Toll-free: 1-877-202-0008
- For more information from the WSIB, please refer to the following:
  - Telephone: 416-344-1000 or Toll-free: 1-800-387-0750.

Exception for staff on early return to work in critical staffing shortages

- In the event that staffing shortages are impacting patient care, guidance and considerations for routine return to work options and options for critical staff in shortages can be found in the following documents:
  - Management of PH Guidance on Cases and Contacts (gov.on.ca) of COVID-19 in Ontario
  - Ontario Health documents specific to your region

Personal Protective Equipment (PPE)

- Acute care settings and public hospitals can refer to PHO's Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 and MOHs guidance document COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities.
- HCWs must be properly trained in the correct method and sequence for donning (putting on) and doffing (taking off) PPE. Training must also be provided in the care, use of, and limitations of the PPE being used.