Ministry of Health
and Long-Term Care

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<u>Directive 03-10(R)</u>
<u>August 6, 2003</u>

TRANSITION DIRECTIVES TO ACUTE CARE FACILITIES IN THE GREATER TORONTO AREA (TORONTO, YORK AND DURHAM REGIONS)

This Directive replaces the following Directives for acute care facilities in Toronto, York and Durham:

- *DIRECTIVE TO ACUTE CARE FACILITIES IN THE GREATER TORONTO AREA (TORONTO, YOURK, AND DURHAM REGIONS) – Directive 03-10, June 16 2003*
- *DIRECTIVES TO ALL ONTARIO ACUTE CARE FACILITIES – Directive 03-04(R),May 13, 2003*

The Ontario Ministry of Health and Long-Term Care advises all acute care facilities to undertake the following procedures:

Facilities are to continue to refer to the Health Canada Guidelines: *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health care* (http://www.hc-sc.gc.ca) for definitions and expanded information regarding routine practices and additional precautions. In addition, facilities should refer to the Ontario Directives 03-05(R) April 24, 2003, *Directives to all Ontario Acute Care Hospitals Regarding Infection Control Measures for SARS units.*

The hospital categorization (0 –3) system will be maintained during transition (see Appendix 1 for SARS categories).

A chart is appended (see Appendix 2) which summarizes the SARS precautions in the transitional environment. The chart also includes the precautions for individuals presenting with respiratory symptoms (unexplained cough, hypoxia, shortness of breath or difficulty breathing)

suggestive of an infectious disease and their use is recommended during the transitional phase until further guidelines are issued.

Hospital Entry Points

- Hospitals may increase the number of entrances in use to the minimum required to allow for reasonable access for staff, patients and visitors.

Screening

- Hospitals are no longer required to actively screen outpatients, staff, or visitors for SARS using the SARS screening tool (see Appendix 3) except as stated below:
  - SARS screening must be performed for all Emergency Department patients and for patients who are direct admissions who bypass the Emergency Department.
  - All Emergency Departments must incorporate SARS screening within the triage process. This will include asking about travel history to affected areas (a list of affected areas is available at http://www.hc-sc.gc.ca) and signs and symptoms for SARS.
  - Taking temperature as part of the screening process is required if the person is experiencing any of the following symptoms:

    - Unexplained myalgia (muscle aches) **OR**
    - Unexplained malaise (severe tiredness or unwell) **OR**
    - Severe headache (worse than usual) **OR**
    - Cough (onset within 7 days) **OR**
    - Shortness of Breath (worse than what is normal for the person) **OR**
    - Feeling feverish, had shakes or chills in the last 24 hours **OR**
    - If the person is staff on working quarantine
  - Anyone who presents in the Emergency Department with respiratory symptoms indicative of a respiratory infection must apply a surgical mask and be triaged into a single room (preferably negative pressure) within 10 minutes of being assessed.
  - Persons accompanying those patients who meet the case definition (for case definitions see Health Canada website at http://www.hc-sc.gc.ca/pphb-dgspsp/sars-sras/sarscasedef_e.html and http://www.hc-sc.gc.ca/pphb-dgspsp/sars-sras/sars-pui_e.html) of fever and respiratory illness with contact history should also be screened for SARS in the Emergency Department.
  - SARS screening for SARS symptoms and risk factors must be incorporated into the nursing admission history. This will include travel history to affected areas and signs and symptoms for SARS to ensure the screening of direct admits or critically ill patients who bypass the triage process.
  - Persons accompanying patients who are being admitted to hospital and who are determined to have SARS symptoms or risks by the nursing admission history must be assessed for SARS and cared for accordingly.
  - Healthcare workers caring for ambulatory outpatients and patients attending outpatient clinics are to follow Routine Practices – *Enhanced* (see Appendix 4). Patients who present with symptoms suggestive of a respiratory illness in outpatient

facilities are to apply a surgical mask and are to be screened for SARS risk factors and contact history. If SARS symptoms or risk factors are confirmed then staff should use SARS precautions (gown, gloves, N95 mask or equivalent, protective eyewear).

- All visitors, healthcare workers (including hospital staff, physicians, midwives students and others coming into direct contact with patients) and hospital staff must self-screen before entering the facility.
- Visitors must not enter the facility if they are feeling ill with symptoms and risk factors as identified on the current SARS Screening Tool.
- Staff must report any onset of fever or respiratory illness to Occupational Health and Safety Services. Health care workers who are not on staff should be strongly encouraged to report to Occupational Health and Safety as well.

Signage

- Prominent signage must be placed at entrances to require self-screening by all visitors, staff and healthcare workers. The signage must include the symptoms and risk factors as identified on the current SARS Screening Tool.

Personal Protective Equipment and Apparel

- Personal protective equipment must be properly used and maintained consistent with the *Regulation for Health Care and Residential Facilities* (Reg. 67/93 s.10) made under the Occupational Health and Safety Act. N95 or equivalent masks must be qualitatively fit tested to ensure maximum effectiveness. (See NIOSH website at www.cdc.gov/niosh - Publication No.99-143).
- SARS precautions (gown, gloves, N95 mask or equivalent, protective eyewear) are to be used by the person doing the screening/triage in the Emergency Department.
- The person doing screening at the time of admission should wear N95 or equivalent mask, protective eyewear and practice good hand hygiene.
- Healthcare workers caring for patients with probable or suspect SARS or persons under investigation for SARS should use protective apparel as outlined in the Directive for Infection Control Measures, April 24, 2003.
- When performing aerosol-generating procedures (e.g. intubation of persons under investigation, suspect or probable SARS) continue to follow the Directive to All Ontario Acute Care Hospitals for High-Risk Procedures - Directive 03-11, June 16, 2003.
- Healthcare workers caring for all other patients should apply Health Canada's Guidelines for Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare.

Surveillance and Patient Management

- Hospitals must continue to implement Active SARS Surveillance as outlined in Appendix 5.
- **Health care workers must maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symptoms**. Fever alone must be considered as a sign of potential infection and should be considered even in the absence of other signs or

an epidemiological link. Therefore, any patient developing the following symptoms or signs on or after admission – fever, unexplained cough, unexplained hypoxia, shortness of breath or difficulty breathing – must be evaluated immediately. If SARS cannot be ruled out for those with fever and a respiratory symptom as listed above, then treat as follows:

a) Transfer to a single room with negative pressure if available. If a single room is not available, cohort similar case presentations (e.g., congestive heart failure cases with other patients with congestive heart failure) and maintain at least one metre spatial separation between beds. If there is more than one patient in a room, the curtains must remain closed between beds to minimize droplet transmission.

b) Patient activity must be restricted i.e. patients remain in their room with the door closed until SARS is ruled out.

c) All visitors and health care workers must take full SARS precautions (gown, gloves, N95 mask or equivalent, and protective eyewear). Where possible, diagnostic and therapeutic procedures (e.g., imaging, haemodialysis) must be done in the patient's room.

d) Patients may be out of the room for essential procedures only and must wear a surgical mask during transport.

- The room must be cleaned according to hospital infection control procedures.
- Restrict movement of all patients who are under investigation for SARS, and those patients with suspect or probable SARS. Use SARS precautions if movement within the facility is required for urgent tests/investigations. Patients must wear a surgical mask during transport and staff must wear full SARS protective apparel (gown, gloves, eye protection, N95 mask or equivalent).
- Discontinue restrictions on all non-SARS patient movement within facility. Patients with symptoms suggestive of respiratory infection must wear a surgical mask during transport if not contraindicated.
- Daily contact sheets must be maintained for all patients with suspect or probable SARS. Upon discharge, the contact sheet must be filed with the patient's chart and becomes part of the medical record.
- Report all suspect and probable SARS cases and persons under investigation (PUI), to Infection Control and the local Public Health Unit.
- Recovering SARS patients must be assessed for ongoing symptoms of SARS prior to discharge. SARS cases are to isolated for at least 10 days after the resolution of the fever and respiratory symptoms. Public Health must be notified of all SARS patients being discharged to the community (as per past Directives on discharging SARS patients).
- For discharged convalescing SARS patients who are to receive in-home services, the hospital must provide the patient with a 48-hour supply of surgical masks, thermometer or disposable thermometer, and contact information for the local Public Health Unit.
- Follow current transfer protocols for inter-facility transfers, *Provincial Inter-Facility Patient Transfer Directive*, May 12, 2003.

Visitors

- Hospitals may discontinue current visitor restrictions. All visitors are to be encouraged to practice good hand hygiene and not to visit patients if they are feeling unwell.
- Visits should be restricted for patients with SARS. Exceptions may be made on compassionate grounds after prior discussion with infection control as well as the medical and nursing staff caring for the patient. Visitors to follow SARS precautions including protective equipment.

Hospital Physical Plant/Hospital Procedures

- Hospitals may increase the volume of patient activity to normal levels.
- Facilities in which SARS units have been in operation may discontinue operating the SARS units in cooperation with the local Public Health Unit and the MOHLTC once all known SARS cases have been discharged.
- Hospitals must be prepared to open or maintain SARS isolation units as necessary.
- Hospitals must be prepared to implement Code Orange as directed.
- Hospitals must establish and maintain negative pressure isolation room(s) with a minimum of 6 air exchanges per hour (9 air exchanges if building a new facility) per Canadian Standards Association standards, in all Emergency Department and Critical Care areas unless already available.
- Hospitals must establish and maintain at least one negative pressure isolation room in the general inpatient area of the hospital. Hospitals must install HEPA filtration units with no air recirculation into the hospital in the areas noted, if negative pressure isolation rooms are not available.
- Hospitals must maintain enhanced surface cleaning in high-risk areas as defined by infection control, including public areas such as washrooms, lobbies and elevators.
- Hospitals must establish and continue on-going hospital promotional campaigns to encourage hand washing and awareness of healthy behaviours (i.e., do not come to work or visit a hospital if you are feeling unwell).
- Hospitals must maintain accurate and timely CritiCall information regarding hospital SARS categories, as well as Emergency Department and Critical Care resources.
- Facilities must reinforce hand washing/hand hygiene with staff, patients and visitors.
- Hospitals are no longer required to provide 24-hour infection control coverage; however, a process needs to be in place to ensure ongoing continuity of infection control practices and consultation during off hours through an assigned hospital designate.

Original signed by

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Dr. James G. Young
Commissioner of
Public Security

Original signed by

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Dr. Colin D'Cunha
Commissioner of
Public Health and Chief Medical
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August 6, 2003

Appendix 1

Definitions:

SARS Precautions:	A new category of precautions requiring the use of N95 masks or equivalent, eye protection (prescription eyeglasses are not protective), gowns, and gloves for contact of all PUI, suspect or probable SARS cases.
Hand Hygiene:	This includes hand washing with soap and running water or alcohol-based hand sanitizers.
SARS Category 0:	Healthcare facility has no known cases of SARS (suspect or probable)
SARS Category 1:	No unprotected SARS exposure – staff and/or patients. Healthcare facility has one or more cases of SARS (suspect or probable).
SARS Category 2:	Any unprotected SARS exposure within the last 10 days but without transmission to staff or patients. The healthcare facility may or may not currently have one or more cases of SARS (suspect or probable).
SARS Category 3:	Unprotected SARS exposure with transmission to health care workers and/or patients. The healthcare facility may or may not currently have one or more cases of SARS (suspect or probable).

Appendix 2

SUMMARY OF SARS TRANSMISSION PREVENTION PRACTICES

The following protective precautions are recommended until aetiology is established, or patient is afebrile for 24 hours:

Diagnostic Category	Hand washing before and after patient contact	N95 mask on attending staff and visitors	Eye protection for all attending staff and visitors	Gown for all attending staff and visitors	Gloves for all attending staff and visitors	Accommodation	Surgical mask on patient
Respiratory Symptoms Suggestive of an Infectious Disease	YES	YES	YES	Follow routine practices for gowning (Appendix 4)	YES	• Single room preferred, cohort like cases • Mask may be used if housed with other patients	YES*
• Persons Under Investigation (PUI) • SARS probable and suspect	YES	YES	YES	YES	YES	• Negative pressure rooms with SARS Precautions	YES*

*Apply surgical mask to patient when staff in the room unless otherwise contraindicated (e.g., paediatric patient) and when patient is outside of patient room.

Appendix 3 **Severe Acute Respiratory Syndrome (SARS) SCREENING TOOL For Ontario Healthcare Settings**

The screening tool must be completed by
all persons entering this facility.

SECTION A:

1. Have you had contact with a person with SARS in the last 10 days while not wearing protection against SARS? **OR** ❐No ❐Yes → Quarantine applies, notify Public Health
2. Within the last 10 days have you been in a health care facility while it was closed due to SARS? **OR**
3. Have you been to a potential SARS exposure site (see www.health.gov.on.ca/english/providers/program/pubhealth/sars/sars_mn.html) during the exposure period? **OR**
4. Are you under quarantine, or have you been contacted by Public Health and put on home-isolation?

SECTION B:

Have you been to [insert affected areas see www.health.gov.on.ca/english/providers/program/pubhealth/sars/sars_mn.html in the last 10 days?

❐No ❐Yes

SECTION C: Are you experiencing any of the following symptoms?

- Unexplained myalgia (muscle aches) **OR**
- Unexplained malaise (severe tiredness or unwell) **OR**
- Severe headache (worse than usual) **OR**
- Cough (onset within 7 days) **OR**
- Shortness of Breath (worse than what is normal for you) **OR**
- Feeling feverish, had shakes or chills in the last 24 hours

❐No ❐Yes

SECTION D: Record the temperature if answer to C is yes.

Temperature	ºC	(Is the temperature above 38ºC?) ❐No ❐Yes

❐ **PASS**

-Response is NO to all Sections A through C

-If only Section B is Yes → Provide education materials about SARS

❐ **FAIL**

-If **only A** is **Yes** → Quarantine and notify Public Health

-If **A** **or** **B** is **Yes** **AND** **C** **or** **D** is **Yes** → Emergency Department or SARS Clinic (Call ahead)

-If **A** **and** **B** are **No** **AND** **C** **and** **D** are both **Yes** → Clinical Evaluation (droplet precautions)

-If only **C** is **Yes** → Home for up to 72 hours with self-isolation and twice daily temperature monitoring; Follow up with Family Doctor, Occupational Health or TeleHealth Ontario (1 866 797 0000) **Or** clinical evaluation and clinical discretion

I declare that to the best of my knowledge the information that I have provided for the purpose of completing the SARS Screening Tool is true.

Interviewee:	**Signature:**	**Date:**

Appendix 4

Routine Practices (Enhanced)

1. Health care providers must comply with existing and updated recommendations for infection control, such as from Health Canada – *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care; Recommendations for Ambulatory Care* – (http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/99vol25/25s4/index.html) and from the College of Physicians and Surgeons of Ontario – *Infection Control in the Physician's Office* – (http://www.cpso.on.ca/publications/infect.htm).

2. All health care providers must wear an N95 mask or equivalent and protective eye-wear when assessing and managing persons with symptoms and signs of a respiratory infection (unexplained cough, hypoxia, shortness of breath or difficulty breathing) suggestive of an infectious disease.

3. Personal protective equipment must be properly used and maintained consistent with the *Regulation for Health Care and Residential Facilities* (Reg. 67/93 s.10) made under the Occupational Health and Safety Act. N95 or equivalent masks must be qualitatively fit tested to ensure maximum effectiveness. (See NIOSH website at www.cdc.gov/niosh - Publication No.99-143).

4. Those who come in first contact with persons who have suspected respiratory infections (e.g., receptionists) must have an N95 mask or equivalent, protective eye-wear and hand sanitation agent immediately available for their own use.

5. All persons with a suspected febrile respiratory illness must be asked if they have been in a SARS affected area in the past ten days. A list of sites with recent local transmission of SARS is available from the World Health Organization at www.who.int/csr/sarsareas, from Health Canada at www.sars.gc.ca or from the Ontario Ministry of Health and Long-Term Care at www.health.gov.on.ca/english/providers/program/pubhealth/sars/sars_mn.html or by calling the exposure hotline at 1 866 670-3155.

   If patient/client responds yes to the above questions, then contact the local Public Health Unit. While with the client, health care providers must use SARS precautions (gowns, gloves, protective eye-wear and N95 mask or equivalent), at least until a determination of SARS by medical examination is made. The client must wear a surgical mask. If a risk of SARS is suspected, continue precautions and contact the local Public Health Unit. The client must be directed to go to an Emergency Department for evaluation (call ahead). Transportation for medical examination must be by private vehicle or an ambulance with the client wearing a surgical mask during transport.

6. As soon as feasible in the encounter process, persons presenting for health care when ill (e.g., family physician offices) must be assessed for the possible presence of a febrile respiratory illness, and subsequent office flow must be managed accordingly to minimize risk to others. Specific factors for consideration include:

a. Identifying those with possible febrile respiratory illness when appointments are booked;
b. Asking those to identify themselves at presentation if certain symptoms suggestive of febrile respiratory illness are present, through prominent office signage;
c. Offering a surgical type mask to those with suspected febrile respiratory illness;
d. Taking a detailed travel history from those presenting with infections;
e. Minimizing accompanying persons to any appointment, when possible;
f. Offering hand sanitizers, such as alcohol based hand sanitizer, to persons upon arrival at the office;
g. Separating those with suspected febrile respiratory illness either to a separate exam room as soon as feasible, and/or to separate seating in the waiting area unless contraindicated or not feasible (e.g., infants); and
h. Maintaining a clean work environment.

In the event that the health care providers become aware that the person they are assessing may meet the criteria for probable or suspect SARS or Persons under Investigation for SARS, they must immediately don apparel for SARS precautions of protective eye-wear, N95 mask or equivalent, gown and gloves, notify Infection Control and the local Public Health Unit and complete the encounter as described below under SARS Outbreak Control Measure, Special Considerations. Any other persons involved in the contact of the person must also wear full protection.

Appendix 5

ACTIVE SARS SURVEILLANCE PROGRAM
For Acute Care Facilities for Toronto, York and Durham Regions

Background:
Active surveillance is an important epidemiological tool that serves a variety of purposes, both during active outbreak situations, and during times when specific outbreaks are not declared.

The ability to identify cases early in an outbreak, or in anticipation of an outbreak, offers enhanced protection to patients, staff visitors and the community at large. It also identifies the need for appropriate infection control precautions and prevents transmission of disease.

The presence of an Active Surveillance Program in acute care hospitals is important for the early identification of "clusters" of cases requiring investigation. Regular attention by clinical nursing and hospital staff to the combination of certain symptoms (e.g., "fever and respiratory symptoms") in a systematic fashion across the hospital environment also provides continuous opportunities for staff education on both infection control practices and other SARS-related information. An Active Surveillance Program minimizes the possibility that SARS cases will be missed.

Further, an appropriately resourced Active Surveillance Program will build and maintain public confidence in the public health and hospital care systems, both during periods of transition and over time.

Ultimately, an efficient system will significantly reduce costs to both human and other resources.

An Active Surveillance Program is not meant to replace Infection Prevention and Control practices already in place in acute care hospitals, but rather to supplement them.

Program Elements:
The Active SARS Surveillance Program described below is designed to apply to all in-patient units, with the exception of Critical Care Units. Another method of case finding will be developed for Critical Care Units.

To have an Active Surveillance Program in place, the following procedures are required:

1. On admission, in addition to questions currently on the SARS Screening Tool, all patients must be asked if they are a health care worker, or if anyone in their household has pneumonia.

2. Unit staff are responsible to make notations on the surveillance sheet (see sample Daily SARS Surveillance Tool, Appendix A) for each of their assigned patients who has an unexplained fever, cough, hypoxia and/or shortness of breath. Copies of the surveillance tool are to be maintained on the in-patient unit.

3. An assigned surveyor (not required to be an Infection Control Practitioner) is responsible for going to all in-patient units each day to review the patient lists and interview staff and/or review patient charts as necessary. (This person will work under the direction of the Infection Control Practitioner at the site).

4. The surveyor and Infection Control Practitioner will review all information gathered by this surveillance to enable Infection Control staff to quickly determine if there are gaps in the identification of at-risk patients and their appropriate isolation. (See sample "SARS Surveillance Report" line list, Appendix B.)

5. The ID physician/Infection Control Committee Chair or medical designate is consulted when additional medical diagnosis and/or evaluation of identified cases is required.

6. Regular analysis of the data is performed by the Infection Control Practitioner in consultation with an ID/Infection Control Physician or, in those sites without an Infectious Diseases physician, by the physician designated by the hospital to review the same.

7. Infection Control is required to immediately notify Public Health of clusters of symptoms or any patients who meet the SARS PUI, suspect or probable case definitions.

Resources:
Hospitals should allocate appropriate additional resources to ensure a successful program.

It is recommended that the following components be added to current Infection Control/Infectious Disease staffing or resource levels:

- 1 additional FTE/500 beds dedicated to Active Surveillance.
- 5-10 hours per week of physician resources for assistance with medical evaluations and surveillance epidemiological review.
- Resources for data management. This should include, but is not limited to, a computer, appropriate programs and personnel for data entry.

Evaluation:
An audit of the surveillance is to be performed by the Infection Control program at regular intervals to ensure all required elements have been implemented as required.

A review and assessment of the Active Surveillance program is required one month after the resolution of the outbreak to ensure that its effectiveness can be maintained and the appropriate resources are in place for the longer term. The facility will establish a process for regular evaluation of the effectiveness of the Active Surveillance program and make changes to the program as appropriate.

Appendix A

Date: ______________________ **Form completed by: ____________________**

Patient Unit: ________________

SAMPLE

Daily SARS Surveillance Tool

Any new onset of symptoms of fever, cough and shortness of breath in patients must be reported to the attending physician and Infection Control immediately.

All patients are to be reviewed daily by unit team leader/charge nurse for any new onset of these symptoms. Names are to be documented below and faxed to Infection Control at extension _____ by 1100 hours daily.

Name	Date of onset	Room #	ID#	Fever >38°C	Cough	SOB	Hypoxia	Currently on Respiratory Precautions?	Action

Appendix B

SAMPLE

INFECTION PREVENTION AND CONTROL PROGRAM
SARS SURVEILLANCE REPORT

Date: ____________________________ **Form completed by: ____________________**

Patient Unit: ___________________________

Name of Patient	Date of Admission/Room #	Date of Onset of Symptoms	Clinical Findings CXR Findings F=fever; My=myalgia SOB; H=headache M=malaise; C=cough; WBC	Symptomatic Relatives e.g. pneumonia in relatives		Has been to an affected hospital /site in the past 10 days		The patient is a health care worker		Has recently traveled to an affected area		New potential SARS Category	Action
				Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**		

Directions for Use:

1. If persons have symptoms but answer “no” to epidemiological links, keep on droplet/contact precautions (N95 mask, eye protection, gown, gloves) X 72 hours and observe for any deterioration or improvement.
2. If persons have symptoms and any confirmed epidemiological link, notify Public Health, Infection Control Officer and maintain SARS precautions
3. If a cluster of symptomatic cases identified with or without geo/epidemiological link, notify Public Health