Directive CC03-04(R)
June 17, 2003

DIRECTIVE TO ALL COMMUNITY CARE ACCESS CENTRES

This Directive replaces the following Directives:

> ***Directives to all Community Care Access Centres Directive CC03-04 May 13, 2003***
>
> *Directives to All Ontario Community Care Access Centres Concerning the Provision of Service to Non-SARS Clients - CC03-03, April 18, 2003.*
>
> *Directives to All Ontario Community Care Access Centres Management of Clients Recovering from SARS and Receiving In-home Service- Directive CC03-02, April 14, 2003.*
>
> *Directive issued to GTA/Simcoe Community Care Access Centres – March 29, 2003.*

This document directs Community Care Access Centres to undertake the following practices. It incorporates precautions to be invoked routinely (Routine Practices – Enhanced), as well as measures to be invoked in the event of another outbreak (SARS Outbreak Control Measures) so that providers have an immediate reference. Notification about SARS outbreaks will originate from the local Public Health Units (see Appendix A- Risk Identification and Management of New SARS Occurrences).

All Community Care Access Centres should 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;* (*http://www.hc-sc.g.ca/pphb-dgspsp/publicat/ccdr-rmtc/99vol125/25s4/index.html*). Community Care Access Centres should maintain regular and specific educational and quality assurance programs to ensure all who carry out their services understand and can comply with these recommendations.

The Ontario Ministry of Health and Long-Term Care directs Community Care Access Centres to undertake the following procedures:

A. System Practices

1. Public Health Units and Community Care Access Centres in their regions must ensure ongoing effective communication as to the current status of SARS and other communicable diseases in their communities.

2. CCACs and service providers must promote hand hygiene and awareness of healthy behaviours (i.e., do not work if you are feeling unwell and are potentially infectious).

B. 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* available at http://www.hc-sc.gc.ca.

2. For exposure to patients/residents with respiratory symptoms (unexplained cough, shortness of breath, fever, or difficulty breathing) or fever suggestive of an infectious respiratory illness, all CCAC staff and service providers are directed to utilize SARS precautions (N95 mask or equivalent, gown, gloves and protective eye-wear) until SARS has been ruled out by medical assessment.

3. All persons with a suspected febrile respiratory illness must be asked if they or family contacts 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/login using the password sarsrep.

   If clients respond yes to the above question, then consult the local Public Health Unit immediately. During contact with the client or while in the home, service providers must use SARS precautions (gowns, gloves, protective eye-wear and N95 mask or equivalent), until a medical evaluation has ruled out SARS.

   The client must wear a surgical mask. 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.

4. Personal protective equipment must be properly used and maintained consistent with the *Occupational Health and Safety Act* Reg. 67/93 s.10. 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).

5. When SARS is not present in the CCAC region, or in the region from which the referral is being made, or in hospitals that are referring clients into the region, no screening of staff or clients is required. If SARS is present, carry out procedures as in Sections C and D below.

C. SARS Outbreak Control Measures

When a Public Health Unit has declared a SARS outbreak that may affect CCAC clients and staff, the CCAC must use the following SARS outbreak control measures:

CCAC Offices

1. All persons entering the CCAC office must screen using the current SARS Screening Tool (attached). If the person fails the SARS Screening Tool, he/she should be assisted to contact the local Public Health Unit.

2 Control entry to each site. Restrict access to one entrance for each building, if possible. Post appropriate person at each entrance to administer the SARS Screening Tool.

3. Post appropriate signage on all entrances. All persons entering CCAC offices including healthcare workers, and visitors, must have a valid reason for entry and must complete the SARS Screening Tool.

Staff

1. All CCAC staff must be screened at the beginning of each shift using the current version of the SARS Screening Tool. The local Public Health Unit will provide an up-to-date screening tool.

2. CCACs must require all service providers to implement screening using the SARS Screening Tool, at the beginning of each shift, for all care providers.

3. Staff who fails the SARS Screening Tool must undergo evaluation as per the Screening Tool's recommendations. If they need to travel to obtain this evaluation, then staff must use a private vehicle or an ambulance with the staff member wearing a surgical mask during transport.

Clients

1. CCACs must use the current version of the SARS Screening Tool to screen all new clients referred for in-home, school and placement services.

2. For home visits by CCAC staff and service providers, persons in the home must be screened using the SARS Screening Tool either by calling ahead and/or immediately upon arrival in the home. If screening on arrival, the person doing screening must wear a N95 mask or equivalent, and protective eye-wear. Those screened must include any visitors or family who will be in contact with the health professional during the visit.

    a. If all individuals pass the SARS Screening Tool, care may be provided using Routine Practices. For exposure to patients/residents with respiratory symptoms (unexplained cough, shortness of breath, fever, or difficulty breathing) or fever suggestive of an infectious disease, all CCAC staff and service providers are directed to utilize SARS precautions (N95 mask or equivalent, gown, gloves and protective eye-wear) until SARS has been ruled out by medical assessment.

    b. If anyone in the home fails the SARS Screening Tool, CCAC staff and service providers will manage the risk as per directions on the SARS Screening Tool. The client (or applicable family member) must be given a surgical mask. Full SARS precautions (gowns, gloves, protective eye-wear and N95 mask or equivalent) must be used by CCAC staff and service providers.

3. CCACs will provide their own staff and service providers with the required precaution supplies.

4. For clients referred to CCACs:

    a. From Category 0 or 1 Hospitals

        i. CCACs will provide services to clients admitted to home care

        ii. CCAC staff and service providers will practise Routine Practices (Enhanced) as part of client care

        iii. For clients convalescing from SARS, see Section D. below

    b. From Category 2 Hospitals

        i. For clients discharged from a Category 2 hospital, the CCAC will confirm with the hospital that the SARS Screening Tool has been completed.

        Unless otherwise directed, CCAC staff will provide service to clients discharged from a Category 2 hospital who have PASSED the SARS Screening Tool administered by the hospital or have been medically assessed and no SARS is suspected. Clients will

be discharged with written instructions from the hospital to self-monitor for symptoms for a period of up to ten days.

For clients convalescing from SARS, see Section D. Below

c. From Category 3 Hospitals

i. For clients discharged from a Category 3 hospital, the CCAC will confirm with the hospital that the SARS Screening Tool has been completed.

ii. CCAC staff and service providers are required to use SARS precautions (gowns, gloves, protective eye-wear, and N95 masks or equivalent) for all direct and indirect client care and during related visits in the home, until the CCAC receives written/fax notification that the period of home isolation has been lifted by the local Public Health Unit.

. d. In-home isolation or quarantine

i. CCAC staff and service providers are required to use full SARS precautions (gowns, gloves, protective eye-wear and N95 mask or equivalent) for all direct and indirect client care, and during related visits in the home, until the CCAC receives written/fax notification that the period of home isolation has been lifted by the local Public Health Unit.

D. For Clients Convalescing from SARS and Receiving In-Home Service

1. For clients recovering from SARS in hospital for whom community services are required, discharge planning must involve the hospital medical staff, the local Public Health Unit, and the CCAC Case Manager.

2. Hospitals and CCACs must consult with the local Public Health Unit if there is a concern about the suitability of the home to which the client is to be discharged. Please see the document "Public Health Management of SARS Cases and Contacts" from the Health Canada website at www.hc-sc.gc.ca

3. The hospital will provide the clients upon leaving with:
   a. 48-hour supply of surgical masks
   b. Thermometer or disposable thermometers
   c. Contact information for the local Public Health Unit

After 48 hours the CCAC will provide the client with surgical masks and other essential supplies as required for care.

4. Clients will receive daily surveillance instructions from the local Public Health Unit upon discharge from hospital including:
    a. Daily symptom screen
    b. Daily compliance assessment
    c. Monitoring household members for symptoms of SARS.

5. The local Public Health Unit will determine the date of discontinuation of isolation.

6. CCAC staff and service providers must use full SARS precautions (gowns, gloves, protective eye-wear, and N95 mask or equivalent) when providing services to a recovering SARS client on home isolation until the CCAC receives written/fax notification that the period of home isolation has been lifted by the local Public Health Unit.

7. CCAC and service providers will maintain logs of all their contacts with convalescing SARS clients.

Dr. James G. Young
Commissioner of
Public Security

Dr. Colin D'Cunha
Commissioner of
Public Health and Chief Medical
Officer of Health

Appendix A

Risk Identification and Management of New SARS Occurrences

1. A system of five risk levels, representing a continuum of risk, will be used to identify the SARS situation in Ontario and define the appropriate public health actions:
    - **Level 1** – No cases in Ontario or in neighbouring/connected jurisdictions
    - **Level 2** – Imported cases in a local jurisdiction in Ontario or a neighbouring/connected jurisdiction, and no evidence of transmission
    - **Level 3** – Transmission within well-defined health care or community settings (e.g., household, school classroom, or workplace)
    - **Level 4** – Limited unlinked cases in the community
    - **Level 5** – Widespread cases in the community

    Levels 2 through 5 may occur in a single jurisdiction (health unit) or in more than one health unit at any given time.

2. The Medical Officer of Health will identify the appropriate risk level for his/her jurisdiction based on the current case status, in consultation with the Public Health Branch of the Ministry of Health and Long-Term Care. Coordination of status when more than one health unit is involved will be the responsibility of the Public Health Branch.

3. Other health units also judged to be at risk because of risk connections (population mixing, commuting, travel etc) to a health unit at a higher level of risk may be included in the classification level for the affected health unit, at the discretion of the local Medical Officer of Health in consultation with the Public Health Branch. This step could also be applied to health units adjacent to another province or a US jurisdiction with SARS.

4. The Medical Officer of Health, in consultation with the Public Health Branch, is responsible for declaring an outbreak (transmission as in Levels 3, 4 and 5) within the health unit jurisdiction as follows:
    - in a specific setting when there is evidence of unprotected exposure or transmission in that setting, or
    - across the health unit, when there is more than one setting involved or there is significant community exposure from an outbreak in a defined setting

5. When an unprotected SARS exposure or evidence of SARS transmission occurs in a health care setting, the facility's outbreak management team and the Medical Officer of Health, in consultation with the Public Health Branch, will decide on the measures to be taken in line with current directives and science. Depending on the circumstances, these may or may not be facility wide. The Medical Officer of Health is responsible for ensuring that appropriate communications take place with other health care providers (e.g., CCAC).