Ministry of Health
and Long-Term Care

Ministère de la Santé
et des Soins de longue durée

Ontario

S · A · R · S

Questions and Answers
December 7, 2003

Directives

Q1: Does the October 22nd *Directive to All Ontario Acute Care Facilities Under Outbreak Conditions* replace the *Directives to All Ontario Acute Care Facilities* issued on May 13th?

A1: The October 22nd directive for Ontario acute care facilities replaces only the outbreak sections of the May 13th acute care directive. Infection control and surveillance standards for acute care facilities are being developed for non-outbreak conditions and are scheduled for release in December 2003.

Q2: Which directive is applicable for Children's Treatment Centres (CTCs)?

A2: All CTCs should follow the *Directive for All Ontario Non-Acute Care Facilities during Outbreak Conditions* (December 4, 2003), including Bloorview McMillan CTC.

Q3: Does the *Directive to All Ontario Health Care Providers in Community Settings and Community Health Care Agencies during Outbreak Conditions* apply to non-residential addiction treatment/withdrawal agencies, community mental health agencies, and community-based AIDS organisations?

A3: No. In the event of an outbreak, agencies offering the above services should follow relevant public health advice advising staff and clients to self-monitor for fever or respiratory symptoms, observe stringent hand hygiene, and stay home and follow the advice of TeleHealth or their physician in the event that symptoms develop.

Q4: What is considered an "essential service" for the purposes of the *Directive to all Ontario Community Care Access Centres (CCACs) and Community Support Service (CSS) Agencies during Outbreak Conditions* (December 4, 2003)?

A4: Essential services refer to the home and community care services provided by a community support service agency, a CCAC case manager and/or contracted service provider, that cannot be suspended in the event of an outbreak because the lack of provision of the care and service would immediately jeopardize the health of the client and/or cause the client to seek out health care services in another part of the health care system. CSS agencies and CCACs will assess client vulnerability and prioritize service and visits on that basis in the event of an outbreak.

Q5: If a SARS patient is discharged from hospital to convalesce at a retirement residence or other group facility, what restrictions should be observed regarding group activities?

A5: In consultation with the attending physician, local public health unit, and CCAC case manager, the person may be required to take meals in their own room and not participate in group activities until the local public health unit (in consultation with the attending physician) confirms that the isolation order is terminated.

Q6: Does the *Directive to All Ontario Non-Acute Care Facilities Under Outbreak Conditions* (December 4, 2003) provide direction beyond what is currently contained in the *Guidelines for Control of Respiratory Disease Outbreaks in Long-Term Care Facilities* (October 2001)?

A6: Yes. The above directive identifies specific infection control and surveillance measures to be taken in the event of a SARS outbreak and provides additional precautions for all Ontario non-acute care facilities.

Q7: Our acute care hospital is small and has little or no negative pressure room capacity. Will we be required to admit SARS patients?

A7: The *Directive to All Ontario Acute Care Facilities Under Outbreak Conditions* (October 22, 2003) and the *Directive to All Acute Care Facilities Regarding the Application of Respiratory and Contact Precautions (Enhanced) with: Patients with Febrile Respiratory Illness and a SARS Contact History; Persons Under Investigation; SARS Patients; and SARS Units* (October 22, 2003) lists the options for patient isolation in order of decreasing preference, beginning with a

negative pressure room with at least 6 air exchanges per hour. The least preferable option is for a semi-private room with its own toilet cohorted with patients who have similar SARS risk factors.

Q8: In a multi-site organization (e.g., large acute care hospital with separate clinics or health care facilities), if the acute care site is a Category 2, does that automatically mean that all other sites are the same Category?

A8: No. If the other sites associated with a health care facility are completely separate physically, they will be able to have a distinct SARS category. Acute care facilities should be cognizant of staff who may work at more than one site in a particular facility, as this may effect whether a separate SARS category is warranted.

Q9: Can health care workers who are under work quarantine use public transit to get to work?

A9: No. If health care workers do not have access to private transportation, then they should check with their employer. Some employer may have a plan in place to assist these workers with transportation.

Personal Protective Equipment (PPE)

Q1: When using the *SARS Risk Management Algorithm*, what precautions should be used if a patient answers "Yes" to one or more of the questions in Section D (SARS Risk Factors), but "No" to questions from all other sections?

A1: Routine practices should be followed if a patient presents without fever, respiratory symptoms or a SARS contact history, but screens positive for SARS risk factors. Routine practices is the Health Canada term to describe the system of infection prevention recommended in Canada to prevent transmission of infections in health care settings. The full description of routine practices to prevent transmission of nosocomial pathogens can be found on the Health Canada website (www.hc-sc.gc.ca/pphb-dgspsp/dpg_e.html#infection).

Q2: When performing high-risk respiratory procedures in outbreak or non-outbreak conditions, what precautions should be used if a patient has a SARS contact history and/or SARS risk factors, but does not have a fever or respiratory symptoms?

A2: Respiratory and Contact Precautions (RCP) should be followed during high-risk procedures if a patient screens positive for either a SARS contact history or SARS risk factors but has no fever or respiratory symptoms.

Q3: Can I re-use my N95 mask?

A3: Health Canada recommends that N95 or equivalent masks should be changed if they become wet, interfere with breathing, are damaged or visibly soiled.

An N95 mask or equivalent that has been exposed to a suspect or probable SARS case is considered contaminated and should be discarded in a designated waste receptacle after the health care worker has left the examination area. Masks must be discarded after each suspect or probable SARS patient contact. Masks are not considered to be a biohazard waste unless bloody.

N95 or equivalent masks are disposable but may be re-used repeatedly by the same health care worker (unless the health care worker was in contact with a suspect or probable SARS case) if the mask is stored in a clean, dry location. Humidity, dirt, and crushing reduce the efficiency of the respirator. (Health Canada 2003-06-05). When masks are worn for prolonged periods of time, a seal-check should be done each time the mask is adjusted or reapplied.

http://www.hc-sc.gc.ca/pphb-dgspsp/sars-sras/ic-ci/sars-respmasks_e.html

Q4: Which companies provide fit-testing services?

A4: Below is a list of companies that provide fit-testing services. Many of the fit test providers offer "Train-the-Trainer" sessions. Depending on the provider, up to 20 staff can be trained at one time. Sessions range from two to four hours. Providers have several trainers and can train up to 120 staff a day. The list below is not exhaustive; you may wish to contact other suppliers in your community.

3M Canada
Ontario Supervisor, Occupational Health Services
Tel: 905 602-3769

Hot Zone
Tel: 1-888-898-8966

Levitt Safety
Tel: 905 829-3299 or 1 800 668-6153

MSA Canada
Tel: 905 602-0338 ext" 5107

North Safety Products
Tel: 416 675-2810

Q5: How are health care workers who are doing home visits expected to dispose of their personal protective equipment (PPE)?

A5: Health care workers should dispose of their single-use equipment in a plastic garbage bag that is tied off securely. This type of waste has been designated as regular waste, not biohazardous waste. In some instances, however, it may not be safe to leave contaminated PPE in a patient home due to other persons or children inadvertently handling the waste. In this case the garbage bag should be tied securely and disposed of into a receptacle outside the home or a waste receptacle designated by the health care worker's agency.

Q6: Are additional precautions required when discharging non-SARS patients who are immune compromised?

A6: No. There should be no different approach to handling non-SARS patients who are immune compromised than any other non-SARS patient.

Q7: Why aren't cleaners required to wear a gown in community and non-acute settings?

A7: Protective equipment is selected based on the amount of contamination anticipated. The gowns are used when it is anticipated that a patients may cough or spit respiratory droplets on their clothing. For cleaners in the community, they are not working directly with the patients but rather the potentially contaminated surfaces. The primary piece of protective apparel when wiping surfaces is a pair of gloves. Other protective equipment should be added as the amount of anticipated contamination goes up.

Screening

Q1: Can non-medical agencies use the *SARS Risk Factor Screening Tool*?

A1: Yes. Non-medical agencies which deliver programs and services to the public are welcome to use the *SARS Risk Factor Screening Tool*.

Q2: Are all Ontario acute care facilities still required to screen for SARS through their Emergency Departments and regular admitting procedures?

A2: Yes. All Ontario acute care facilities are still required to use the *SARS Risk Factor Screening Tool* to screen for SARS in the current environment. Non-

outbreak surveillance standards are being developed and are currently scheduled for release in December 2003.

Surveillance and Monitoring

Q1: Why are we directed to keep a daily log during an outbreak?

A1: A daily log is required to ensure appropriate contact tracing and follow-up can be done on patients or clients if required by the local public health unit.

Q2: How long do we have to keep the log record?

Q2: Logs should be maintained at least until the outbreak is declared over by the local public health unit. It may be prudent, depending on the facility's involvement with and proximity to the outbreak, to keep logs for a significantly longer period of time. Facilities are advised to seek advice on this issue from legal counsel and senior administrators.