

Final Report of the Infection Control Standards Task Force: Non-Acute Institutional Settings

Preventing Respiratory Illnesses Protecting Residents and Staff In Non-Acute Care Institutions

Recommended Infection Control and Surveillance Standards for Febrile Respiratory Illness (FRI) in Non-Outbreak Conditions

March 2004

Table of Contents

Introduction.....	3
The Care Environment.....	4
The Context for Recommended Surveillance and Infection Control Practices	4
Definitions.....	6
I. Proposed Standards for Comprehensive Infection Control Programs for Febrile Respiratory Illnesses in Non-Acute Care Institutions	8
1. Screening.....	8
2. Ongoing Surveillance.....	12
3. Reporting.....	12
4. Infection Control Practices.....	15
5. Education and Communication.....	17
6. Implementation in the Non-Acute Care Institutional Setting	19
II. Best Advice and Outstanding Issues for the MOHLTC.....	22
Communication and Distribution.....	22
Resources	22
Supportive Legislation.....	23
Evaluation	23
Links to Education and the Regulatory Colleges.....	23
Appendix 1.....	24
Appendix 2	26

Introduction

Early in 2003, the Province of Ontario experienced first hand the impact of a new, highly contagious respiratory illness (severe acute respiratory syndrome or SARS). By September 2003, Ontario had had 375 probable and suspect cases of SARS and recorded 44 SARS-related deaths. Many of the SARS infections occurred in health care settings where ill patients sought care, and over 40% (164) of the cases were in health care workers.

While most of the infections occurred in acute care settings, a rehabilitation hospital was closed down when a patient with SARS was transferred there from an acute care hospital. This highlighted the risk of spread between facilities, and the potential risk to patients in non-acute care institutions who, because of age or a chronic health problem, are particularly vulnerable to respiratory infections.

The spread of SARS in health care settings has reinforced the understanding that infection disease is both a public health and occupational health and safety issue. This caused the health care system to re-examine the infection control and surveillance practices now in place to prevent the spread of respiratory infections – both in SARS outbreak and non-outbreak conditions. During the SARS outbreaks, the Ministry of Health and Long-Term Care (MOHLTC) issued directives to health care institutions and community and primary care providers designed to contain the spread of the disease. In December 2003, the MOHLTC issued directives for infection control during any future SARS outbreaks.

In the fall of 2003, the MOHLTC also established the Infection Control Standards Task Force to develop recommendations for infection control practices in SARS non-outbreak conditions, which would help Ontario protect against all severe and emerging respiratory illnesses, and prevent disease outbreaks. In December 2003, based on the recommendations of the task force, the MOHLTC issued infection control and surveillance standards for febrile respiratory illness (FRI) in *acute care* hospitals in non-outbreak conditions.

Although these standards represent the best advice for infection control in all health care settings, the task force recognized that they would have to be modified for use in non-acute care settings. The MOHLTC established an additional task force to review the standards for infection control in *non-acute care* institutions, including long term care facilities, chronic care hospitals, rehabilitation hospitals, mental health facilities and some children's treatment centres.¹ This report represents the best advice of that task force for a consistent, province-wide approach to preventing droplet-spread respiratory illnesses in non-acute institutions in non-outbreak conditions. The recommendations:

- reinforce the role of the general public, health care workers and organizations in preventing the spread of respiratory illnesses
- address both public health and occupational health and safety issues, and highlights the role that Joint Health and Safety Committees will play in addressing infection control and related worker safety issues

Relationship with Other Infection Control Guidelines and Standards

Standards for the control of respiratory infection do not replace infection control guidelines and standards already in place for other illnesses. They should be integrated with other guidelines, and be part of an organization-wide effort to maintain appropriate standards for infection control practices.

¹ For the purposes of this document the term non-acute care institution refers to all of the settings within this sector. Settings such as Homes for Special Care, and Approved Homes are not required to incorporate these standards into their policies. They should, however, be cognizant of the basic practices of infection control appropriate in any group setting.

- identify best practices in the areas of surveillance (including screening and reporting) and infection control (including education) in non-acute settings
- recommend steps to help non-acute institutions implement these practices effectively.

The Care Environment

The Populations Served

Non-acute care institutions in Ontario differ from acute care institutions in the types and levels of service residents/patients require due to the nature of their conditions and illnesses. While acute care settings focus on short-term, intensive treatment for acute health problems, non-acute care settings provide care further along the continuum of care such as rehabilitation services, psychiatric services, and ongoing, longer term care for people with chronic, complex or long-term health problems. Some children's treatment centres are included in non-acute care institutions and provide services to inpatients, outpatients and ambulatory clinics. The residents/patients admitted to non-acute care institutions and the clients who attend their day programs and clinics may require care over weeks, months or years. For many residents, long-term care facilities are their permanent home. The risk of spread of respiratory illnesses in these settings is due to five main factors:

- people are transferred in from acute care settings or the community where they may have been exposed to a respiratory illness
- the settings are open, and volunteers and visitors come and go, which increases the risk of exposure to infections
- the population tends to be older, or have longer term or chronic health problems and is, therefore, more vulnerable to infection
- people in some of these settings live in close proximity to one another for long periods of time
- staff may perform some high risk procedures that can create sprays and splashes, such as nebulized therapies and aerosol humidification.

The Context for Recommended Surveillance and Infection Control Practices

Because some non-acute care institutions deal with highly vulnerable populations, they have experience in disease surveillance, and have developed practices and protocols to monitor for infectious diseases and prevent/manage outbreaks.

The task group recommends that the procedures non-acute care institutions use to detect and prevent febrile respiratory illness:

- build on the systems already in place**
- become part of a comprehensive approach to infection control.**

Non-acute care institutions use a variety of terms to describe their settings, and the people they serve. In this document the term "non-acute care institutions" refers to non-acute care hospitals, long-term care facilities, centres, ambulatory and day programs.

The people served in non-acute care institutions are referred to as "patients" in hospitals, "residents" in long-term care facilities, and "clients" in ambulatory and day programs. For the purpose of this document, the term "resident/patient" is used to refer to all the people served in these settings.

As part of a commitment to move to common national practices, the task force supports the Health Canada recommendations set out in the document: *Infection Control Precautions for Respiratory Infections Transmitted by Large Droplet/Contact: Infection Control Guidance in a Non-Outbreak Setting, When an Individual Presents With a Respiratory Infection*. (Monitor the Health Canada website at www.hc-sc.gc.ca .) and the Ontario Ministry of Health and Long-Term Care document *Preventing Respiratory Illnesses, Protecting Patients and Staff: Infection Control and Surveillance Standards for Febrile Respiratory Illness (FRI) in Non-Outbreak Conditions in Acute Care Hospitals*. (website: http://www.health.gov.on.ca/english/providers/program/pubhealth/sars/docs/docs3/dir_infec_control_010604.pdf)

The task force recommends that non-acute care institutions in Ontario use the Health Canada guidelines as the basis for their infection control practices.. In addition, these settings should continue to use the provincial guidelines and standards established for managing infections in non-acute care institutions including:

- *The Long-Term Care Facility Program Manual (1993, amended 1995, 1998)*
- *A Guide to the Control of Respiratory Disease Outbreaks in Long-Term Care Facilities, (October 2001)*

Any variations from these guidelines should be based on new information received from Health Canada or Public Health, and as identified in future legislation, directives, protocols, standards, criteria, the province's history and experience with outbreaks of respiratory illness, and on the nature/capacity of the non-acute institutional settings.

Health Canada plans to develop algorithms for infection control in different settings where health care is delivered. These should be reviewed and adopted for use in Ontario, if appropriate.

NOTE: Health Canada's guidelines are for severe respiratory infection (SRI), while Ontario's guidelines are for febrile respiratory illness (FRI). FRI and SRI are two different points along the continuum of respiratory illness. SRI is a more severe or advanced FRI (see box and definitions on next page).

Roles and Responsibilities

With regard to infection control in non-outbreak conditions in non-acute care institutions:

- The federal government establishes national guidelines for infection control.
- The MOHLTC establishes provincial standards and expectations for infection control and surveillance in non-acute settings.
- The non-acute care institutions develop the policies, protocols, and implementation plans required to meet provincial expectations and be consistent with national guidelines.
- The Professional Regulatory Colleges develop the professional standards for health professionals. It is the health professional's responsibility to comply with both his/her college's standards and the standards, policies, protocols and expectations of the employing organization.

Definitions²

Aerosolization: The process of creating very small droplets (droplet nuclei) of moisture that may carry microorganisms. The aerosolized droplets can be light enough to remain suspended in the air for short periods of time and facilitate inhalation of the microorganisms.

Airborne transmission: Occurs by dissemination of either airborne droplet nuclei or evaporated droplets (sub micron particles) containing microorganisms, that remain suspended in the air for long periods of time. These microorganisms can be widely dispersed by air currents and may be inhaled by persons even when standing a distance away from the source patient.

ARDS: Adult Respiratory Distress Syndrome is the rapid onset of progressive malfunction of the lungs usually associated with the malfunction of other organs due to the inability to take up oxygen. The condition is associated with extensive lung inflammation and small blood vessel injury in all affected organs.

Cluster: A grouping of cases of a disease within a specific time frame and geographic location suggesting a possible association between the cases with respect to transmission.

Droplet Precautions: (see also Routine Practices) The type of precautions used to protect health care workers when caring for patients with respiratory infections. These infections are transmissible principally by large respiratory droplets, particularly when the health care worker is within 1 metre of the ill patient. They are spread more effectively when the patient is coughing or sneezing. The precautions consist of a water resistant surgical or procedure mask and eye protection or face shield for the health care worker. Droplet precautions are also used to protect the mucous membranes of the eyes, nose and mouth of the health care worker during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions (e.g., airway suctioning).

Febrile Respiratory Illness (FRI): The definition of FRI is different in outbreak and non-outbreak conditions. During non-outbreak conditions, when SARS is considerably less likely, FRI includes a fever of greater than 38°C **and** new or worsening cough or shortness of breath. In outbreak conditions, when SARS is more likely, FRI includes a fever of greater than 38°C **or** new or worsening cough or shortness of breath.

Infection Control Practitioner: The designated individual must be a registered nurse or a registered medical laboratory technologist and should possess the expertise or demonstrate the willingness to acquire expertise in infection control (Ministry of

Criteria for FRI

- **fever >38° C and new or worsening cough or shortness of breath not otherwise explained.**
- **abnormal temperature (for the long-term care [elderly] population)**

Criteria for SRI

- **fever >38° C and new or worsening cough or shortness of breath not otherwise explained**
- **admitted to hospital**
- **abnormal chest radiograph consistent with severe pneumonia or ARDS**
- **no alternative diagnosis after 72 hours**

and

- **living in or traveling to a potential zone of re-emergence within the past 30 days**

or

- **being in close contact with a symptomatic person who has been in a potential zone of re-emergence within the past 30 days**

² Source: Directive to All Ontario Acute Care Facilities Under Outbreak Conditions. ACO-03-05, October 22, 2003. Appendix 1, Glossary.

Health and Long-Term Care Facilities Program Manual 1011-01M3.20 Note page 9 December 20, 1993

Non-Outbreak: For purposes of this document, this refers to the condition when there are no reported outbreaks of SARS anywhere in the world.

Nosocomial Infection: A nosocomial or hospital acquired infection is one for which there is no evidence that the infection was present or incubating at the time the patient was admitted to the hospital facility.

N95 Masks: In this document N95 masks are referred to the more precise term - N95 Respirators

Outbreak: For the purposes of SARS activity, an *outbreak* is defined as local transmission of SARS. This represents Level IV of the Regional Response Levels Outbreak definition which describes seven levels of outbreak. The local Medical Officer of Health is responsible for declaring an outbreak. An outbreak may be setting-specific (e.g., a hospital with transmission) or health unit wide (e.g., transmission in more than one setting or significant community exposure). In declaring an outbreak the local Medical Officer of Health takes into account global and neighbouring jurisdiction conditions and the potential impact of those conditions.

Reference: Regional SARS Response Levels and Paradigm (see Appendix 2).

Respiratory Symptoms: New or worse cough (onset within 7 days) OR new or worse shortness of breath (worse than what is normal for the patient).

Routine Practices (See also “Droplet precautions”): The Health Canada term to describe the system of infection prevention recommended in Canada to prevent transmission of infections in health care settings. These practices describe prevention strategies to be used with all patients during all patient care, and include:

- Hand washing or cleansing with an alcohol-based sanitizer before and after any direct contact with a patient.
- The use of additional barrier precautions to prevent health care worker contact with a patient’s blood and body fluids, non intact skin or mucous membranes.

The wearing of masks and eye protection or face shields where appropriate to protect the mucous membranes of the eyes, nose and mouth during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions.

Gloves are to be worn when there is a risk of body fluid contact with hands; gloves should be used as an additional measure, not as a substitute for hand washing.

Gowns are to be worn during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions that could contaminate uniform or clothing.

The full description of routine practices to prevent transmission of nosocomial pathogens can be found on the Health Canada website (http://www.hc-sc.gc.ca/pphb-dgspsp/dpg_e.html#infection).

Severe Respiratory Illness (SRI): Temperature greater than 38° C and cough or difficulty breathing not otherwise explained, admitted to hospital, chest x-ray consistent with severe pneumonia or ARDS and no alternative diagnosis after 72 hours; **and** living in or traveling to a potential zone of SARS re-emergence within the past 30 days **or** being in close contact with a symptomatic person who has been in a potential zone of SARS re-emergence within the past 30 days.

Work for a health care organization: The intent of this is to capture all those who may be in contact with residents/patients or clients in their work. This would include those who work in hospitals, non-acute care institutions, doctors’ offices, laboratories, community care access centres, service provider agencies, long-term care facilities, physiotherapy clinics, community health centres, and public health units.

I. Proposed Standards for Comprehensive Infection Control Programs for Febrile Respiratory Illnesses in Non-Acute Care Institutions

The task force recommends that Ontario adopt a surveillance/infection control program in all non-acute care institutions that is appropriate for those settings.

Surveillance

A surveillance program for febrile respiratory illness (FRI) is designed to help the non-acute care institution and the local public health unit recognize and contain the spread of febrile respiratory illness, (FRI), manage residents/patients and others who have FRI, and address any breakdown in infection control practices or workplace health and safety measures. Surveillance includes screening and reporting.

For long term care facilities: “A designated infection control practitioner on staff shall be a member of the infection control committee and shall be responsible for the surveillance and outbreak management activities of the infection control program.” Ministry of Health and Long-Term Care Facilities Program Manual 1011-01 M3.20 page 9 December 20, 1993

1. Screening

Screening is designed to help health care professionals, infection control practitioners, and organizations identify individuals with potential FRI who may pose a risk to residents/patients and/or health care providers. The goals are to:

- identify all residents/patients admitted to non-acute care institutions who have symptoms of a respiratory illness (e.g., fever >38°C and cough or difficulty breathing) and who have been to or had contact with a sick person from a high risk area.
- minimize the contact with and/or droplet spread to other residents/clients or to health care workers
- identify potential clusters of cases (see section on reporting).
- The current high risk areas may be found on the World Health Organization website at: www.who.int/csr/sars/en This site should be monitored regularly for currency.

Recommendations

1.1. All residents/patients admitted to non-acute care institutions should be assessed for indicators of FRI/SRI. Non-acute care institutions should develop a consistent approach to screening in SARS non-outbreak conditions that reflects the relative risk posed by different groups in the setting and builds on existing practices and protocols.

Non-acute care institutions deal primarily with four groups of people:

- residents/patients who are admitted to the facility

Infection Control Practitioner

By MOHLTC Standards, each long term care facility is to have a designated infection control practitioner, (ICP). Other non-acute institutions may have ICPs, infection control staff or designates. For the purposes of this document, those staff performing the responsibilities of infection control are referred to as infection control practitioners.

- staff and students who work in the organization
- clients who come to the facility to attend ambulatory and day programs.
- visitors and volunteers who assist with programs under the direction of staff

In non-outbreak conditions, the risk is greatest in residents/patients at the time of admission/readmission to the institution and from staff. In the view of the task force, non-acute care institutions should have a formal screening process in place for these two groups. With the other two groups -- clients who attend ambulatory and day programs and visitors/volunteers – non-acute care institutions should promote self-screening for respiratory and other contagious infections (including the responsibility to not enter the institution with infections that may put others at risk). See also 1.9.

Many non-acute care institutions (e.g., long-term care facilities) already have in place a system for screening admissions for symptoms and signs of a range of infectious diseases, including respiratory illnesses (i.e., fever, cough, shortness of breath), gastrointestinal infections, and antibiotic resistant (nosocomial) infections. However, some non-acute care institutions may not routinely screen new admissions/readmissions, and will have to develop a screening process.

1.2 The screening tools currently used to assess/screen people being admitted to non-acute care institutions should include questions that would help identify possible FRI and its source:

- does the resident/patient have a new/worsening cough or shortness of breath? and**
- does the resident/patient have a fever or abnormal temperature?**
- where has the resident/patient come from (e.g. another institution/ facility)?**
- has the person traveled to a high risk area in the last 30 days? where?**
- has the person had contact with an ill person who has traveled to a high risk area in the last 30 days?**

Note: The proposed travel-related screening questions differ from those suggested by Health Canada on one point: the task force recommends that Ontario use a 30 day window for past travel to an affected area or contact with a sick person from an affected area (as opposed to the 14 days from onset of illness suggested by Health Canada). The Ontario modification avoids any confusion about the incubation period and provides extra vigilance for Ontario.

Note: Many elderly people will not present with a fever despite having an active infection. Therefore the question regarding fever has been modified for the non-acute population to include an abnormal temperature.

1.3 Those non-acute care institutions that are not currently screening new admissions for a range of health conditions should do so, asking the screening questions found in the sample screening questionnaire developed for acute care facilities and modified for use in non-acute care institutions (see next page).

**Screening Questions to be asked of Residents/Patients
as Part of an Active Screening Process**

i Do you have new/ worse cough or shortness of breath?

- if 'no', stop here (no further questions)
- if 'yes', continue with next question:

ii Are you feeling feverish, have you had shakes or chills in the last 24 hours?

In the long-term care sector, ask if there is an abnormal temperature

- if 'no', take temperature; if >38 C, continue with next questions, otherwise stop (no further questions)
- if yes, take temperature and continue with next questions:

Initiate droplet precaution if yes to i and ii.

iii Is any of the following true?

- Have you lived in, traveled to or visited a high risk area within the last 30 days?
- Have you had contact in the last 30 days with a sick person who has traveled to a high risk area?

Residents/Patients with FRI (fever and respiratory symptoms) and 'yes' to any of these exposures/conditions are potentially severe respiratory illness (SRI).

*Initiate droplet precautions and notify infection control if "yes" to i, ii and iii.
Infection control practitioner to notify public health.*

Additional questions to be asked of all admitted patients:

iv. Do you work for a health care agency or organization? If so, which one(s)

**v. Are/were you a resident of a long-term care institution? If so, which one(s)
(Not to be asked within a long-term care setting.)**

Initiate droplet precautions and notify infection control practitioner if "yes" to i, ii and either iv or v.

1.4 Non-acute care institutions should also establish procedures for self screening all persons who come and go from the institution in order to raise awareness of the risk, reduce the spread of infectious diseases in that setting, and be able to track visitors who may have been exposed.

In the task force's view, in non-outbreak conditions, it is not necessary to screen volunteers, visitors or clients who attend clinics and day programs or events at the institution. However, non-acute care institutions should still use every opportunity to reduce the risk of these individuals bringing infectious diseases into the institutions.

Non-acute care institutions should establish education/self-screening programs for these persons that would reinforce personal responsibility for preventing the spread of disease. While the format of the educational program is up to the individual organization, the programs would consist of:

- signage at every entrance reminding people that residents/patients are highly susceptible to

infectious diseases and asking them not to enter if they have respiratory symptoms (i.e., cough, shortness of breath, fever)

- hand hygiene stations at every entrance
- a sign-in book, which enables the facility to know who has been in the building and who they visited in case a health problem develops (this system may also be useful in determining the number of people in the facility in case of emergencies).
- information for clients who attend clinics and day programs, asking them to postpone and reschedule visits if they are ill
- education programs for volunteers
- a requirement that all private duty nurses and health care workers hired by families to provide care for residents have training in infection control and are aware of the facility's infection control policies and practices.

1.5 Staff should initiate droplet precautions with anyone being admitted to a non-acute care institution who has symptoms of an FRI along with anyone accompanying that person, until the etiology of the infection is known. Please see Health Canada – *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care*, website: <http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/99pdf/cdr25s4e.pdf>

1.6 Residents/patients with FRI should wash their hands before putting on a mask. Staff should assist any resident/patient who is unable to implement precautions on his or her own (i.e., people with dementia, neurological disorders or physical disabilities) with hand hygiene. Staff doing so should first put on PPE for droplet precautions themselves.

1.7 The results of the screening questions should be documented in the resident's/patient's health record and communicated to areas of the institution where the patient is admitted and treated. Results should also be forwarded to the infection control practitioner in long-term care institutions.

In long-term care facilities “A designated infection control practitioner on staff shall be a member of the infection control committee and shall be responsible for the surveillance and outbreak management activities of the infection control program.” Ministry of Health and Long-Term Care Facilities Program Manual 1011 M3.20, page 9, December, 1993.

1.8 When the screening/assessment of new admissions is completed by another agency (e.g., a Community Care Access Centre, the referring hospital), the receiving non-acute care institution should work with that organization to ensure it incorporates the FRI-related travel questions into its assessment.

1.9 Non-acute care institutions should ensure that an adequate supply of the personal protective equipment (PPE) required to protect against droplet-spread infections is readily available at the point of first resident/patient contact.. (i.e., kept at the admission desk, clinic reception desk and nursing stations.)

2. Ongoing Surveillance

Due to their residents'/patients' vulnerability, many non-acute care institutions already have in place procedures for ongoing surveillance. The goals are to:

- identify early signs of infections so they can be treated. (Some facilities report new symptoms on a daily basis, using "tick-off" or surveillance line-list forms.)
- monitor for possible clusters of infections so outbreak control measures can be implemented
- prevent outbreaks of infectious diseases in the facility
- protect resident/patient and staff health
- identify a potential outbreak or an outbreak in its early stages, and institute control measures as soon as possible.

Recommendations

2.1 Non-acute care institutions should continue to monitor residents/patients for signs of possible infections, including observed respiratory symptoms, a diagnosis of an infection by a physician, a lab report indicating an infection, a prescription for new antibiotics, or any clusters of ill residents/patients.

2.2 Staff responsible for Occupational Health should:

- be notified by the manager/department/unit head/infection control practitioner of all employees/contract workers who stay home due to illness or any possible clusters of ill staff**
- contact all employees / contract workers who stay home due to illness after 72 hours and clarify that they do not have FRI. The notes from the review should be kept confidential.**
- notify infection control practitioner (who will be the contact with the institution's medical director and with public health) about clusters of employees/contract workers who are home ill after 72 hours due to FRI. This reporting should be done in a non-nominal manner (i.e.: no names) to protect the workers' right to confidentiality.**

3. Reporting

Reporting is designed to ensure that information that can be used to identify or follow potential cases of FRI is communicated and shared appropriately, while still safeguarding people's right to confidentiality. The goals are to:

- identify and report all residents with potential FRI or SRI (i.e., FRI plus the travel history or contact with someone who has traveled)
- ensure appropriate infection control practices are used for residents/patients with FRI
- involve the occupational health and safety designate and the infection control practitioner in a timely way to ensure workers are protected
- identify and manage clusters of cases quickly and effectively

- prevent/contain the spread of FRI within the non-acute care institution
- report to the local public health unit the information, such as the number of cases of FRI, required to prevent/contain/manage community spread
- fulfill legal requirements to report occupationally acquired FRI.
- effective internal and external communication is essential to ensure a common understanding of risks, identify possible clusters or outbreaks in a timely way, and take appropriate action.

Recommendations

Internal Reporting: to Infection Control

3.1 The institution's infection control practitioner or designate should be notified, using established procedures, of:

- all residents/patients who have FRI
- all residents/patients who meet the Health Canada definition for SRI
- clusters of residents/patients with FRI.

3.2 Staff should be alert to clusters of FRI in residents/patients in the facility. Institutions must develop mechanisms to enable staff to identify and report these clusters to the infection control practitioner or designate. See *Guide to the Control of Respiratory Disease outbreak in Long Term Care Facilities, 2001, Public Health Branch, MOHLTC*

3.3 Occupational health should notify the infection control practitioner or designate of clusters of employees/contract staff who are absent from work for 72 hours with FRI. The information should be reported non-nominally to protect the employees' right to confidentiality.

Internal Reporting: to Occupational Health and Safety

Infectious disease is an occupational health and safety issue, as well as a public health issue. It is critical for non-acute care institutions to develop collaborative relationships among occupational health, the infection control practitioner and public health to prevent disease spread in the workplace, and ensure roles and responsibilities are understood.

The primary responsibility for monitoring respiratory infections in a non-acute care institution rests with the infection control practitioner, while the designated occupational health staff person plays a significant supportive role. The local public health unit only needs to become involved when there is a potential outbreak in the facility or when employees have a reportable disease – although the infection control practitioner and occupational health staff can consult with the local public health unit as required.

Some of the functions and powers of the Occupational Health and Safety Representative and the Joint Health and Safety Committee at a workplace are described in Part 2, section 9 of the Regulation for Health Care and Residential Facilities Regulation 67/93, made under the *Occupational Health and Safety Act*. This committee's consultative role in establishing infection control measures, procedures and providing training is set out in sections 8 and section 9 of Regulation 67/93 (the Regulation for Health Care and Residential Facilities). (See web site: http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90o01_e.htm)

3.4 If an occupationally acquired infection is probable or confirmed in a health care worker, it

should be reported, non-nominally, to the institution's Joint Health and Safety Committee or the Occupational Health and Safety representative.

- 3.5 The Joint Health and Safety Committee or representative should work with the infection control practitioner/committee to develop, implement and maintain appropriate infection control standards that protect workers.**

External Reporting: to Other Health Care Organizations

- 3.6 When a resident/patient who is being admitted from another facility is identified as having FRI, the infection control practitioner should inform the facility that initiated the transfer. Under subsection 14(2), Regulation 965 of the Public Hospital's Act (PHA) the patient's consent is required. In the long-term care sector, under the Nursing Homes Act, the information can be provided to a long-term care facility to which the resident is being transferred.**

This will help the referring facility identify any clusters.

- 3.7 In the unlikely event that someone who works for another health care organization is admitted to a non-acute care institution with FRI, that organization should be notified through the Occupational Health and Safety designate..**

Any process established for notifying another health organization's occupational health service must comply with section 63(2) of the Occupational Health and Safety Act and with section 39(1) of the Health Protection and Promotion Act (HPPA), which restricts an employer's access to a worker's health records.

External Reporting: to Public Health

- 3.8 The non-acute care institution's infection control practitioner must notify public health under the provisions in the *Health Protection and Promotions Act*, using established procedures, seven days a week during office hours of:**

- residents/patients admitted to the institution who meet the Health Canada criteria for SRI
- clusters of residents/patients or health care workers with FRI .

Many non-acute care institutions already have established relationships with the local public health unit, and work closely with public health to manage outbreaks.

External Reporting: to the Ministry of Labour

- 3.9 When the Occupational Health staff or designate is informed of a possible cluster of FRI in staff, it will notify the Ministry of Labour in accordance with existing occupational health and safety legislation.**
- 3.10 When the employer is informed of a staff person with probable or confirmed occupationally acquired infection, the employer will notify the Ministry of Labour in accordance with existing occupational health and safety legislation.**

Sections 51 and 52 of the Occupational Health and Safety Act set out when reports relating to critical injuries and occupational illnesses must be made to the Ministry of Labour. The information that must be included in such a report is set out in section 5 of Regulation 67/93 (the Regulation for Health Care and

Residential Facilities made under the *Occupational Health and Safety Act*).

4. Infection Control Practices

Infection control includes a constellation of practices and precautions used to prevent disease transmission, and includes the knowledge and skills required to choose and maintain appropriate precautions.

Infection control practices are intended to protect residents/patients, health care providers and the public from exposure to infectious diseases. In environments that treat people with infectious diseases, there is no such thing as “total protection” or “zero risk” for patients, visitors or health care workers, but there are steps that non-acute care institutions can take to significantly reduce the risk. The goals of the proposed standards for infection control practices are to:

- ensure all non-acute care institutions are working to the same standard
- ensure all non-acute care institutions are implementing evidence-based infection control practices
- ensure non-acute care institutions are continually working to reduce the risk to health care workers and patients, including promoting appropriate immunizations.

Recommendations:

4.1 Non-acute care institutions should use the Health Canada *Infection Control Precautions for Respiratory Infections Transmitted by Large Droplet/Contact: Infection Control Guidance in a Non-Outbreak Setting, When an Individual Presents With a Respiratory Infection* as the basis for establishing infection control standards and practices for FRI.

This can be found on the following website:

http://www.hc-sc.gc.ca/pphb-dgsp/ps/sars-sras/pdf/sars-icg-nonoutbreak_e.pdf.

4.2 Non-acute care institutions should ensure that all the infection control processes and procedures implemented to prevent the spread of FRI comply with existing occupational health and safety legislation.

These are set out in the Regulation for Health Care and Residential Facilities (Regulation 67/93) made under the *Occupational Health and Safety Act*.

4.3 When there is disagreement about appropriate infection control practices among those caring for a patient with FRI, staff should follow the practice of using the higher level of precautions until consensus can be reached.

Each non-acute care institution should develop a process for resolving conflicts about the need for precautions.

4.4 The appropriate level of precaution should be driven by the procedure being undertaken and the resident's/patient's symptoms. Infection control programs should reinforce the importance of droplet precautions for staff providing direct care.

Based on the knowledge now available about the spread of respiratory illnesses, the task force supports the Health Canada recommendations that droplet precautions are the appropriate response during significant patient contact in non-outbreak conditions. This means that water resistant surgical masks and eye protection will provide an appropriate barrier. (When dealing with an airborne illness, such as

tuberculosis, see Health Canada recommendations for airborne disease spread. Please see *Health Canada – Routine Practices*, Section 1.2.)

4.5 For residents of long-term care institutions with FRI, the institution should implement section 4.2.1 Restriction of Cases to their Rooms in the Guide to the Control of Respiratory Disease Outbreaks in Long-Term Care Facilities(October 2001), (Public Health Branch, MOHLTC). It states: “Restrict cases (ill residents) to their room until 5 days after the onset of acute illness or until symptoms have completely resolved (which ever is shorter). For some pathogens the period of communicability may be longer than 5 days, but for practical reasons, this could be applied to outbreaks caused by respiratory viruses other than influenza. Restrictions of ill residents to their room is recommended as long as it does not cause the resident undue stress or agitation and can be done without applying restraints.”

4.6 Staff in non-acute care institutions should be given time and education to become comfortable with any new standard that represents a different level of precaution from that currently in use in their work setting. They should also be educated in risk assessment and best practices.

Because some recommended infection control standards represent a change from practices used during the recent SARS outbreak (e.g., water resistant surgical masks instead of N95 respirators), it may take time for staff to understand the basis for the change, become comfortable with the new surveillance methods and infection control precautions, and adopt new practices (see section on education). Until staff become confident in their ability to assess risk and choose appropriate precautions (i.e., best practices), they should have the option of continuing to use higher levels of precautions. However, the setting should discourage the use of any precautions that are not supported by science – particularly those that, if misused, increase the risk of exposure to FRI.

4.7 Those non-acute care institutions that conduct high risk procedures (e.g., nebulized therapies, aerosol humidification) should follow the MOHLTC Directive HR03-12, October, 2003, “Directive to all Ontario Acute Care Facilities for High-Risk Respiratory Procedures”.

This directive is currently under revision and will be released in two documents, for outbreak and for non-outbreak conditions.

4.8 Non-acute care institutions that provide services to residents/patients with airborne illnesses (e.g. tuberculosis) should have a negative pressure room that meets Health Canada standards and follow airborne precautions, including use of N95 respirators. (Please see Health Canada – *Guidelines for Preventing the Transmission of Tuberculosis in Canadian Facilities*, website: www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/96vol22/22s1/index.html).

4.9 All negative pressure rooms should be monitored regularly (at least monthly and upon patient admission) according to the Health Canada Guideline in 4.8. to ensure negative pressure is maintained.

While negative pressure rooms are routinely used to provide care for people with airborne infections, they can also be used for high risk procedures that create aerosols in residents, with droplet-spread infections. The use of negative pressure rooms in these situations is designed to protect other residents/patients not staff, who will already be using appropriate protective equipment (e.g., N95 respirators).

4.10 In the case of a respiratory outbreak that is not SARS, the institution should follow the *Guide to the Control of Respiratory Disease Outbreaks in Long-Term Care Facilities*.(October 2001) (Public Health Branch, MOHLTC).

4.11 Non-acute care institutions should implement recommended practices to clean the physical environment (see Health Canada – Infection Control Guidelines Handwashing, Cleaning, Disinfection and Sterilization in Health Care, volume 24S8, December, 1998). In particular, the institutions should focus on:

- cleaning surfaces that have frequent hand contact**
- using appropriate hospital-grade disinfectant**
- ensuring adequate contact time.**
- final cleaning after an infection is over and/or the patient is discharged.**

5. Education and Communication

Education and communication programs are designed to ensure that both the public and health care workers understand the reason for infection control practices for FRI and their responsibilities in preventing disease spread. The goals of education and communication programs are to:

- provide clear, accessible information
- explain the science that forms the basis for the infection control standards
- ensure health care providers have the support and opportunity to develop the skills required to implement infection control standards
- ensure infection control practitioners have the support and opportunity for ongoing education/certification required to remain competent and current in their role in non-acute care settings
- describe the roles and responsibilities of the public/patients, health care providers, the institution, the occupational health service, the infection control practitioner the infection control committee, public health, Joint Health and Safety Committee/Occupational Health and Safety representative and the Ministry of Labour
- encourage the kind of open communication and collaboration that helps prevent infectious diseases.

To support best practices, non-acute care institutions must do more than hand staff copies of new directives, guidelines or standards. They must provide active teaching programs with significant input from infection control and occupational health experts.

Infection control practitioners should also be encouraged to be involved in infection control networks in their regions.

Recommendations:

5.1 All non-acute care institutions should develop active, formal orientation and ongoing education programs for all staff to ensure they have the knowledge, skills and confidence to maintain infection control standards for FRI.

5.2 Non-acute care institutions should ensure that all staff receive education in infection control practices and procedures annually or more frequently.

Education programs should emphasize:

- risk assessment skills
- the appropriate use of personal protective equipment and infection control practices for each case of FRI
- hand hygiene (including hand washing and use of alcohol based sanitizers)
- components of Routine Practices and Transmission-based precautions such as water resistant surgical masks for staff and residents/patients, eye protection for staff, and the appropriate use of gloves and gowns (See Definitions)
- appropriate cleaning and/or disinfection of care equipment, supplies and surfaces or items in the care environment (for example, beds, curtains, walls, floors), sanitation practices, biohazardous waste
- safe application and removal of personal protective equipment
- those procedures that are considered high risk and why
- the principles behind transmission-based precautions and cohorting of patients
- individual staff responsibility to keep residents/patients and fellow staff members safe
- the role of the Joint Health and Safety Committee/Occupational Health and Safety representative and the infection control committee/practitioner in developing infection control education programs
- policies and procedures with contact list to facilitate early communication in event of outbreak
- other legislated requirements
- the importance of yearly influenza vaccinations for residents and staff.

Education programs should be flexible enough to meet the diverse needs of the range of health care providers and other staff who work in these settings.

The local public health unit is a resource and can provide assistance in developing and providing education program.

5.3 Non-acute care institutions should measure the effectiveness of their education programs and their impact on practices (see also 6.5 Quality Management)

They may also keep attendance records of staff attending educational in-services/training.

5.4 Non-acute care institutions, in conjunction with public health and the MOHLTC, should also educate the public, patients and individual health care workers about their personal responsibility for disease prevention and the steps they can take to minimize the spread of febrile respiratory illness, including: staying home when they are sick, covering their mouth when coughing and/or sneezing, washing their hands frequently and, in the case of health care workers, reporting any symptoms of febrile respiratory illness to their managers, departments, or occupational health services in accordance with workplace policies.

Implementation

6. Implementation in the Non-Acute Care Institutional Setting

Many non-acute care institutions already have well established surveillance and infection control programs designed to detect infectious diseases and prevent/manage outbreaks. Most have the structures and processes in place to support infection control for FRI and for other diseases. However, given the potential impact of a respiratory outbreak on residents and the heightened awareness of infection control, it may be appropriate for these organizations to review their policies and practices to ensure they reflect current best practices

Recommendations:

6.1 Each non-acute care institution should review its internal policies to ensure they support a common approach to screening and surveillance for FRI.

These policies should address the following issues:

- who completes screening assessments
- who the information is reported to and who reviews and analyzes the results
- where the information is kept (i.e., screening information in the resident's/patient's chart and surveillance information centrally)
- the process for resolving conflicting opinions on the need for precautions
- how the organization will monitor the implementation of infection control standards, and assess compliance and quality improvement initiatives
- processes related to policies (e.g., responsibility for screening review of surveillance data)
- links with other organizations for education and infection control (e.g., public health, other non-acute care organizations, infection control expertise in the community)
- how the organization will evaluate the effectiveness/impact of education programs and know who has attended education sessions
- contingency plans in case of an outbreak.

6.2 Non-acute care institutions should have an active infection control committee with a public health representative.

6.3 Non-acute care institutions should establish the roles and responsibilities of occupational health practitioners, infection control practitioners, and the Joint Health and Safety Committee/Occupational Health and Safety representative in implementing a comprehensive infection control program. At a minimum, institutions must ensure that the roles played by the Joint Health and Safety Committee/Occupational Health and Safety representative and infection control practitioner fully comply with existing legislation.

Some of the functions and powers of the Joint Health and Safety Committee are described in section 9 of the Regulation for Health Care and Residential Facilities (Regulation 67/93), made under the Occupational Health and Safety Act. The committee's consultative role respecting the establishment of measures and procedures to deal with infection control and training in same, at health care and residential

facilities, is set out in section 8 and 9 of Regulation 67/93 (the Regulation for Health Care and Residential Facilities).

6.4 Non-acute care institutions that do not have adequate infection control expertise on staff or are not able to support a full-time infection control practitioner should explore other models for accessing this expertise (e.g., through public health or through other nursing or medical IC professionals.)

Note: all LTC facilities must have a designated infection control practitioner as required under the Ministry of Health and Long-Term Care Facilities Program Manual 1011-01M3.20 Page 9 December, 1993.

Options to consider are:

- developing links with other organizations to support a “hub and spoke” approach to infection control and occupational health expertise (i.e., the “hub” group could develop a resource kit and education programs to be shared with a number of similar “spoke” organizations)
- sharing an infection control practitioner and/or occupational health practitioner with other facilities
- collaborating with other institutions to create a full-time position for an infection control practitioner or a combined infection control/occupational health practitioner or they may choose to have both practitioners shared
- taking advantage of expertise/resources in the community (e.g., public health, Community and Hospital Infection Control Association)
- arranging for designated staff to receive specialized training in infection control.

6.5 Non-acute care institutions should identify organizational strategies to foster a healthy environment and reinforce with residents/patients, staff, volunteers, and visitors of their responsibility for helping to maintain that environment.

This could include integrating the expectations into the organization’s mission statement, staff job descriptions, performance appraisals, contracts with families, visitor information, and patient charter (if one exists).

6.6 Non-acute care institutions should develop quality management programs designed to ensure surveillance and infection control policies and programs are implemented as intended and have the desired effect in the environment.

A quality management program should measure:

- the staff’s compliance (i.e., knowledge and practice) with the organization’s policies and procedures
- the availability of resources (e.g., supplies, educational materials, contact phone numbers)
- accurate reporting and recording of infections for timely interventions, analysis, benchmarking and ongoing quality improvement of the infection control program
- the effectiveness of current practices
- the effectiveness of a contingency plan in the event of an outbreak.

II. Best Advice and Outstanding Issues for the MOHLTC

For Ontario to successfully implement and maintain infection control standards for respiratory illnesses in SARS non-outbreak conditions, the task force recommends that the MOHLTC consider the following issues and recommendations.

Communication and Distribution

Non-acute care institutions already have a culture that supports surveillance and infection control. Many facilities have extensive ongoing surveillance programs in place. Although the recommendations in this report build on current practice, non-acute care institutions will still require clear information about the standards for surveillance and infection control in non-outbreak conditions.

The MOHLTC should develop a dynamic, effective communications strategy to support the standards and recommendations.

The strategy could include:

- a provincial teleconference launch of the standards (teleconferences worked extremely well in this sector during the SARS outbreak)
- a tool kit that organizations can use to help educate staff and implement the standards. The tool kit would include:
 - copies of the standards
 - information about the standards in a variety of different languages
 - a power point presentation that organizations can adapt and use in staff orientation
 - standard signage
 - education tools (e.g., videos, web-based materials, other resources, Qs and As) that are flexible enough to meet needs of the broad range of audiences (employees, private practitioners, volunteers, family members)
- concerted efforts to ensure that all sectors receive the same basic information about surveillance and infection control for FRI
- a system to ensure ongoing communication of any changes or updates, which make it clear which previous recommendations or standards they replace

The MOHLTC should support the launch of the standards with a public education campaign designed to make people more aware of the risks of FRI, their responsibility in infection control, and the steps being taken to keep health care settings safe.

Resources

Implementing the standards will require resources for; education, communication, equipment, and processes. The single greatest gap in the non-acute care institutional sector is the lack of infection control and occupational health practitioners. Most facilities add these responsibilities to those of other staff, many of whom may not have had training in infection control and are often not able to give this part of their job the time it requires.

Non-acute care institutions are also concerned about the impact of equipment costs on their budgets.

The standards must be supported by adequate resources – both human and financial.

Supportive Legislation

Some legislation, particularly the new confidentiality legislation which focuses on privacy, may have a negative impact on organizations' and professionals' ability to implement the proposed infection control standards. Practitioners and institutions will not implement the surveillance standards if they think it puts them at risk of legal action or the process is unduly cumbersome.

The MOHLTC should review legislation that may limit the ability of non-acute care institutions to implement effective infection control standards, and recommend the amendment of legislation to ensure that the reporting requirements recommended in this report are authorized by law.

Evaluation

The MOHLTC and the non-acute care institutions should develop an effective way to evaluate the implementation and effectiveness of the proposed standards in non-acute care institutions, and refine the program based on feedback from those settings.

In identifying ways to assess the program, the MOHLTC should consider integrating the evaluation into existing, ongoing quality management processes, such as the accreditation programs and program reviews, rather than establishing a new assessment or auditing process. For example:

- for long-term care facilities, the MOHLTC should revise the existing infection control standards and criteria in the Long-Term Care Facility Program Manual and the corresponding audit tools used by compliance advisors and facility staff
- many non-acute care institutions voluntarily participate in an accreditation process through the Canadian Council on Health Services Accreditation, which assesses achievement in many programs, including infection control.
- In the task force's view, the MOHLTC will achieve good compliance with the recommendations in this report if:
- staff have the information they need, understand the scientific basis for the standards, understand their roles, and know what protection/precautions they should use to protect their patients and themselves
- organizations are adequately resourced to implement the program and provide ongoing education.

Links to Education and the Regulatory Colleges

Both the regulatory colleges and the education system may be able to play a part in implementing and maintaining the proposed standards:

- the education system by integrating the prevention and infection control standards into their curricula and ensuring all graduating students are familiar with infection control practices

- and the regulatory colleges by informing their members of the standards, and working through their quality assurance and education programs to improve compliance.

The MOHLTC should consult with the health professionals, schools and regulatory colleges regarding their role in promoting best infection control practices, and ways to implement effective guidelines and promote best practices in this vital area.

The education system should provide more opportunities for training in infection control. Infection control should be a compulsory part of all health care providers' education. In addition, additional courses should be available for those who want to specialize, and to support continuing education.

APPENDIX 1**TASK FORCE MEMBERS**

NAME	TITLE/ORGANIZATION
Dr. Bonnie Henry CHAIR	Associate Medical Officer of Health Toronto Public Health
Lora Armstrong RN, HBScN	Infection Control Practitioner Long Term Care SOPIC member, CHICA-Canada Member
Mary Bayliss	Professional Practice Advisor College of Respiratory Therapists of Ontario
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Gladys Brett	Administrator Altamont Long-Term Care Facility
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Mary Anne Carson	Manager, Communicable Diseases Halton Region Public Health
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Karen Ellis-Scharfenberg	Practice Consultant College of Nurses of Ontario
Margaret Evans	Director of Care Carefree Lodge Toronto
Helen Ferley	Administrator Seniors' Health Centre
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Dr. Barry Goldlist	Infection Control Committee Chair, Medical Director Geriatric Rehab Program Toronto Rehabilitation Institute
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Nancy Johnson	Labour Relations Officer Ontario Nurses' Association
Tamara Johnson	Infection Control Co-ordinator ONHSS/OLTC St. Joseph's Villa
Louise Kromkamp	Administrator Avalon Retirement Centre
Helen Lampi RN MHSc	Manager, Program Operations Providence Centre
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Dr. Peter Pendergast	Chief Psychiatrist Whitby Mental Health Centre
Julia Stemp	Manager, Quality Practice College of Medical Laboratory Technologists of Ontario
Allison Stuart	Executive Lead Emergency Management Unit Ministry of Health and Long-Term Care
Anne-Luise Winter RN BScN MHSc	Nurse Epidemiologist Influenza, ARO and Infection Control Unit Public Health Branch, MOHLTC
Dr. Bryna Warshawsky	Associate Medical Officer of Health Director Communicable Disease & Sexual Health Services Middlesex-London Health Unit
Lynne Wilkins	Manager Occupational Health & Safety and Infection Control West Parke Health Care Centre
Helen Zulys	Consultant, Member and Professional Relations Ontario Hospital Association

APPENDIX 2

Regional SARS Response Levels and Paradigm

SARS Response Levels

A series of SARS Response Levels has been developed to describe the appropriate responses required for each level of risk of SARS in a given geographic area. The risk assessment takes into account the provincial, national and international geographic and epidemiologic contexts. These SARS Response Levels are based on the *proximity* to the area(s) in the world where SARS transmission is occurring, the *likelihood* of local transmission, and the *ability to epi-link* cases.

Within this document SARS cases are those that meet current accepted SARS case definitions.

These guidelines are written to assist local public health units in determining the SARS Response Level for each jurisdiction.

The two most important factors that determine a local jurisdiction's recommended SARS Response Level are:

- the local SARS activity level (based on local communicable disease and hospital surveillance reports), and
- the SARS activity level of jurisdictions that are *related* to or *connected* to the local jurisdiction by virtue of admixing of populations and patient transfers (based on the reported SARS activity level).

Paradigm

Following the description of the SARS Response Levels is a chart outlining the possible scenarios that could occur in a community under each Response Level. The scenarios overlay the description of Response Levels with that of the conditions of SARS Health Care Facility Categories. For example, a community at SARS Response Level 2 (no local cases but cases in other parts of the province) can only have health Care facilities

that are at a SARS Health Care Facility Category 0 (no active SARS cases; no unprotected exposure or transmission). Also provided are specific instructions for acute care facilities and pre-hospital care providers at each Response Level.

Response Levels

Level 0 – NO ACTIVITY

- *No detected SARS activity anywhere in the world*

Level 1 – ALERT

- *No detected cases in the local jurisdiction, in Ontario, or in neighbouring / connected jurisdiction(s), but cases identified elsewhere in the world*

Level 2 – ONTARIO (PROXIMAL) PRESENCE

- *No detected cases in the local jurisdiction, but one or more case(s) reported in Ontario or a neighbouring / connected jurisdiction(s)*

Level 3 – LOCAL PRESENCE

- *Case(s) detected in the local jurisdiction and no evidence of local transmission*

Level 4 – LOCAL TRANSMISSION IN DEFINED SETTINGS

- *Transmission in the local jurisdiction, within defined healthcare, household, or community settings (e.g. hospital, clinic, classroom, workplace, funeral gathering, faith group, recreational settings), but without documented community spread*

Level 5 – LIMITED COMMUNITY SPREAD

- *Limited unlinked cases in the community; identification of cases beyond defined institutional or household settings, unrelated to travel*

Level 6 – WIDESPREAD COMMUNITY SPREAD

- *Widespread unlinked cases* in the community, with multiple communities affected.

The local Medical Officer of Health (MOH) will assess the information available and determine the response level for the jurisdiction. The local MOH will advise the Public Health Branch of the Ministry of Health and Long-Term Care of any assessment of Response Level 3 or above. The Public Health Branch, as per internal protocols, will alert the provincial SARS Executive Committee (which will have the MOH of the affected public health unit as a participant) for determination of appropriate next steps for the institution, the community and the province. When more than one health unit is affected, coordination and communication of Response Levels will be the responsibility of the Public Health Branch.

Some considerations are as follows:

- An appropriate response by a local health unit may be more aggressive depending on the context of SARS activity in the local and surrounding areas. For example, a jurisdiction may judge itself to be at increased SARS risk because of *risk connections* (significant population admixing, patient transfers, commuting, travel etc.) to an area experiencing a higher level of SARS activity, and may choose a more aggressive level of response (i.e., may “upgrade” its response). The related/connected area could be another Ontario health unit jurisdiction, another province or U.S. jurisdiction, or an international destination with significant travel to the local jurisdiction.
- *When a jurisdiction is severely affected (e.g., at a Response Level 4, 5, or 6), all other jurisdictions (rather than just neighbouring / connected jurisdictions) should consider increasing their response to a level closer to that of the more severely affected jurisdiction, even if they have no known cases in their local jurisdiction (increase from Response Level 1 or 2 to a higher level).*
- A *range of risk* exists within individual regional Response Levels, and the response should be tailored to the estimated risk (e.g., the particular interventions adopted and/or the settings to which they would apply). Particularly within Response Level 4, there may be instances of minimal transmission for which the declaration of an *outbreak* and the related responses are not required. Examples include: a single imported case with limited transmission in the case’s household, or limited well-recognized transmission in a delineated setting.
- *For the purposes of this classification scheme, an outbreak is defined as local transmission of SARS (Response Levels 4, 5, and 6), rather than as a single case or several imported cases. The local health unit region’s SARS Response Committee is responsible for declaring a SARS outbreak, and may be setting-specific (e.g., a hospital with transmission) or health unit region-wide (e.g., transmission in more than one setting or significant community exposure).*

- *Any health unit region with a Health Care Facility SARS Category 1 or 2 hospital will be at Response Level 3 or above.*
- *Any health unit region with a Health Care Facility SARS Category 3 hospital will be at Response Level 4, or above.*
- As health unit regions generally have more than one hospital, and occasionally, hospital corporations overlap health units, an individual hospital's category will not always align with the health unit regions Response Level. Refer to the Ontario SARS Response Levels Paradigm below for how the regional levels, healthcare facility SARS categories and other providers' precautions interact.

Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Activities	Patient Transfer and Pre-Hospital Care Activities
<p>0 No activity anywhere in the world.</p>	<p>0 No active SARS cases. No unprotected exposures or transmission.</p>	<p>FRI surveillance using Risk Factor Screening Tool.</p>	<p>Self screening of staff, outpatients and visitors</p>	<p>Non-outbreak practices. Have SARS non-outbreak and outbreak procedures prepared and in place.</p>	<p>Non-outbreak transfer process and non-outbreak practices.</p>

Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Activities	Patient Transfer and Pre-Hospital Care Activities
<p style="text-align: center;">1</p> <p>Activity elsewhere in world</p>	<p style="text-align: center;">0</p> <p>No active SARS cases. No unprotected exposures or transmission.</p>	<p>FRI surveillance using Risk Factor Screening Tool.</p> <p>Ensure ED and admitting are aware of affected areas in Ontario or</p>	<p>Self screening of staff, outpatients and visitors.</p> <p>Post names of affected areas in Ontario or other nearby jurisdictions on signage.</p>	<p>Non-outbreak practices.</p> <p>Review information from MOHLTC and local health unit.</p> <p>Have preparatory meetings with local</p>	<p>Non-outbreak transfer process and non-outbreak practices.</p> <p>Base to review information from MOHLTC and local health unit including names of affected areas in Ontario or other nearby jurisdictions.</p> <p>Ensure paramedics receive in-service on procedures.</p>

<p>2 No local cases but cases exist in <u>other</u> areas of Ontario or other nearby jurisdictions</p>		<p>other nearby jurisdictions.</p>		<p>SARS management committee to ensure a state of readiness</p>	
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Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Activities	Patient Transfer and Pre-Hospital Care Activities
<p>3</p> <p>Local cases without transmission in your region</p>	<p>0</p> <p>No active SARS cases. No unprotected exposures or transmission.</p> <p>1</p> <p>Active SARS cases. No unprotected exposures or transmission.</p>	<p>FRI surveillance using Risk Factor Screening Tool.</p> <p>Ensure ED and admitting are aware of affected facilities in your region and other regions in Ontario.</p>	<p>Self screening of staff, outpatients and visitors.</p> <p>Post names of affected facilities in your region and other regions in Ontario on signage.</p>	<p>Non-outbreak practices.</p> <p>Survey for any admitted patients who may have been transferred in from an affected facility.</p> <p>Inform all staff to declare to Occupational Health if they have worked at any of the affected facilities.</p>	<p>Non-outbreak transfer process and non-outbreak practices.</p> <p>Base to review information from MOHLTC and local health unit including names of affected areas in Ontario or other nearby jurisdictions.</p> <p>Ensure paramedics receive in-service on procedures.</p>

Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Directive to Follow and Other actions	Patient Transfer and Pre-Hospital Care Directives to Follow
<p>3 Local cases without transmission in your region</p>	<p>2 Active SARS cases, with unprotected exposures, but no transmission.</p>	<p>Intensive Hospital surveillance using SARS Risk Factor Screening Tool.</p>	<p>Self screening of staff, outpatients and visitors. Post names of affected facilities in your region and other regions in Ontario on signage.</p>	<p>Non-outbreak practices.</p>	<p>Non-outbreak practices. If associated with a SARS Category 2 or 3 hospital, then use outbreak practices.</p>
	<p>3 Active SARS cases, with transmission</p>	<p>This scenario is not possible by definition. When transmission has occurred within the hospital, then the entire region moves up to Level 4</p>			

Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Directive to Follow and Other actions	Patient Transfer and Pre-Hospital Care Directives to Follow
<p style="text-align: center;">4</p> <p>Local cases with transmission in “defined” settings (i.e., for the sake of this application this means transmission in hospitals)</p>	<p style="text-align: center;">0</p> <p>No active SARS cases. No unprotected exposures or transmission</p> <p style="text-align: center;">1</p> <p>Active SARS cases. No unprotected exposures or transmission</p>	<p>FRI surveillance using Risk Factor Screening Tool with Outbreak Management Algorithm.</p> <p>Ensure ED and admitting are aware of affected facilities in your region and other regions in Ontario.</p>	<p>Active screening of staff, outpatients and visitors using the SARS Risk Factor Screening Tool.</p> <p>Staff self screen at home and do not come to work if they are ill.</p>	<p>Outbreak directive.</p> <p>Survey for any admitted patients who may have been transferred in from an affected facility.</p> <p>Inform all staff to declare to Occupational Health if they have worked at any of the affected facilities.</p>	<p>Outbreak transfer process and outbreak practices.</p>

Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Activities	Patient Transfer and Pre-Hospital Care Activities
<p style="text-align: center;">4</p> <p>Local cases with transmission in “defined” settings (i.e., for the sake of this application this means transmission in hospitals)</p>	<p style="text-align: center;">2</p> <p>Active SARS cases, with unprotected exposures, but no transmission.</p>	<p>IH surveillance.</p>	<p>Active screening of staff, outpatients and visitors using the SARS Risk Factor Screening Tool.</p> <p>Staff self screen at home and do not come to work if they are ill.</p>	<p>Follow Outbreak directive.</p> <p>Survey for any admitted patients who may have been transferred in from an affected facility.</p> <p>Inform all staff to declare to Occupational Health if they have worked at any of the affected facilities.</p>	<p>Outbreak transfer process and outbreak practices.</p>

Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients & Staff	Screening Procedures	Acute Care Directive to Activities	Patient Transfer and Pre-Hospital Care Activities
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<p style="text-align: center;">4</p> <p>Local cases with transmission in “defined” settings</p> <p>(i.e., for the sake of this application this means transmission in hospitals)</p>	<p style="text-align: center;">3</p> <p>Active SARS cases, with unprotected exposures or transmission</p>	<p>IH surveillance.</p>	<p>Active screening of staff, outpatients and visitors using the SARS Risk Factor Screening Tool.</p> <p>Staff self screen at home and do not come to work if ill.</p>	<p>Outbreak directive.</p> <p>Survey for any admitted patients who may have been transferred in from an affected facility.</p> <p>Inform all staff to declare to Occupational Health if they have worked at any of the affected facilities.</p> <p>Hospital may have some or all programs closed depending on individual circumstances as decided by MOHLTC, local health unit and hospital.</p>	<p>Outbreak transfer process and outbreak practices.</p>
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Ontario SARS Response Levels Paradigm

Regional SARS Response Level	SARS Health Care Facility Category	Surveillance within Health Care Facility of Patients and Staff	Screening Procedures	Acute Care Directive to Activities	Patient Transfer and Pre-Hospital Care Activities
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<p>5 Limited community spread</p>	<p>Respond as per Community SARS Response Level 4 or lower depending upon extent of SARS with or without transmission in healthcare facilities.</p>			<p>Outbreak transfer process and outbreak practices.</p>	
<p>6 Wide community spread</p>					

The health care facility SARS category is more likely than not to determine the regional SARS level above Response Level 2.

It is possible that there might be local SARS cases in a region without cases in any or some regional hospitals.

Only the hospitals with SARS cases will be designated as SARS Category 1 or higher.

Where a region is at Response Level 3 or higher due to community cases with or without transmission, all of the healthcare facilities and providers in that region should:

- maintain a high level of awareness of the local SARS epidemiology,
- communicate with the local health unit; and,
- have plans in place for managing their facility, clinic or practice if they see SARS patients or are designated a Hospital SARS Category 1 facility or higher.