**STATEMENT OF COMMITMENT AND POLICY**

During the COVID-19 pandemic South Bruce Grey Health Center is dedicated to providing optimal care for patients with suspected or confirmed COVID-19 as well those with non-COVID-19 conditions, while insuring a safe environment and following provincial guidelines. Policies and procedures relating to the pandemic will be reviewed on a frequent ongoing basis, and updated to align with current provincial guidelines and best practice in order to prevent the spread of COVID-19 within the health are setting.

**DEFINITIONS**

**Aerosol-Generating Medical Procedure (AGMP**): A medical procedure that generates droplets/aerosols which may expose staff to respiratory pathogens and are considered to be a potential risk for staff and others in the area.

**Airborne Infection Isolation Room (AIIR):** A room that is designed, constructed and ventilated to limit the spread of airborne microorganisms from an infected occupant to the surrounding areas of the health care setting. This is also known as a negative pressure room. NOTE: The Canadian Standards Association uses the term Airborne Isolation Room (AIR).

**Airborne Precautions:** Used in addition to Routine Practices for clients/patients/residents known or suspected of having an illness transmitted by the airborne route (i.e., by small droplet nuclei that remain suspended in the air and may be inhaled by others).

**COVID-19:** COVID-19 is the infectious disease caused by the coronavirus, SARS-CoV-2, which is a respiratory pathogen. WHO first learned of this new virus from cases in Wuhan, People’s Republic of China on 31 December 2019.

**APPLICATION**

All SBGHC staff and physicians are to apply the infection control principles outlined in all Infection Control policies

**PROCEDURE**

**Dedicated Entrances and Screening**

All persons entering SBGHC shall be screened to assess risk of COVID-19. Screening questions will be adjusted as necessary to meet the current screening/risk requirements as applicable to the current state of the pandemic.

Patients and visitors will be actively screened at the designated hospital entrance. All persons will screen ‘negative’ or ‘positive’ and will be directed to appropriate space or denied entry depending on reason for visit.

Staff shall use the designated staff entrance, and complete the screening application at the kiosk or on their person device prior to entry. If a staff member fails screening, they must report this to their manager and Occupational health to determine if entry into the workplace is allowed. Staff shall not enter until clearance is given. Staff must carefully monitor for symptoms and not report to work if symptoms are present until reviewed with Occupational Health (or manager on call during off hours). If a staff member develops symptoms while at work, they must immediately notify their supervisor and Occupational health. Instructions will be given regarding testing and follow up. Staff should wipe down their immediate work area (if applicable) using hospital supplied cleaner, and/or notify housekeeping as required.

**Patient Face Coverings**

All persons entering the facility must wear a face covering, unless eligible for a provincial exemption. Face coverings may include (but are not limited to) surgical/procedure masks, fabric face masks or bandanas. Patients who arrive without a face covering will be offered a procedure mask at the screening booth. Persons who state they are eligible for an exemption and are unable to wear a mask will be offered a face shield, and/or appropriate department specific procedures will be used to minimize contact with other persons.

Inpatients do not require face masks while in their own room, but if there are no contraindications, and the patient is able to understand and comply, face masks should be worn when patient is outside the room (ex. testing, ambulation, etc). Patients should be given 1 procedure mask per day, to be worn when out of the room, and stored in a clean space.

**Indication for COVID-19 Testing**

The following people should be tested for COVID-19:

* Any person with symptoms consistent with COVID-19 (physician discretion may be used if symptoms related to other diagnosed condition)
* Any patient transferred between facilities (i.e. leaving one facility and entering another, even within same multi-site organization, regardless of symptomology), are to be tested upon admission to the destination facility
* Close contacts of persons exposed to a positive case of COVID-19, and as directed in COVID-19 outbreaks (in consultation with IPAC and Public Health)
* Asymptomatic testing should only be completed as indicated by provincial testing guidelines, and is not typically recommended for general public

**Laboratory Specimen Collection**

Molecular testing (e.g. Polymerase chain reaction PCR test) detects virus or viral fragments, and is used for diagnostic purposes. Serology testing is only available for clinical use under very specific clinical indications and should not be used for screening and diagnosis of acute COVID-19 infection.

 Preferred Specimen Types (with optimal sensitivity):

* Nasopharyngeal Swab
* Lower Respiratory Tract Sample (ex. sputum sample)

 If the above are not possible, the following can be used (less optimal, lower sensitivity):

* Deep nasal
* Throat AND both nares

In a symptomatic patient in whom COVID-19 is suspected, only a single (1) specimen (nasopharyngeal (NP) preferred) is required for laboratory testing. A single positive result is sufficient to confirm the presence of COVID-19.

**Isolation**

Patients being tested for COVID-19, or who are positive for COVID-19, require droplet/contact isolation with airborne isolation for AGMPs. A negative pressure room is not required, unless requiring an aerosolizing procedure or there is a high likelihood of requiring an AGMP.

Patients waiting a COVID-19 test result is for patient requiring testing prior to discharge to LTCH (who have no other indication for testing), or patients who require testing prior to surgery (who have no other indication for testing) are the only exception, and do **not** require isolation waiting for results.

Patients requiring isolation for COVID-19 (PUI or confirmed case) should be isolated in private rooms whenever possible. When not possible, bed-space isolation should be used, and patients should be cohorted with patients of similar risk (ex. Cohort two COVID-19 positive patients).

**Aerosol Generating Medical Procedures (AGMPs)**

During the COVID-19 pandemic, AGMPs shall be done under airborne precautions. Airborne isolation is to be maintained while the aerosolizing procedure is being completed, and for one hour after, unless there is signage on the room indicating a faster adequate air exchange. See Airborne Isolation Policy for further details.

There are AGMPs that pose a higher risk to health care providers when performed on patients with COVID-19. When clinical judgement dictates that patients need these procedures, an N95 mask and airborne precautions should be used. These include:

* + CPR (with emergent intubation or manual ventilation)
	+ Tracheotomy/tracheostomy insertion
	+ High Frequency Oscillating Ventilation
	+ Open Suctioning (‘deep’, nasopharyngeal or tracheal)
	+ Non-invasive positive pressure ventilation (CPAP, BIPAP)

Some AGMPs should be avoided whenever possible. These include:

* + Sputum induction (therapeutic or diagnostic)
	+ Large volume nebulizers for humidity
	+ High flow oxygen therapy (see following slides for what is and what is not considered an AGMP regarding oxygen therapy)

See **Appendix A** for a list of what is and what is not considered an AGMP (as listed on August 11 2020 Ontario Health Guideline)

**De-escalation of patients / Duration of Isolation Precautions**

Infection Prevention and Control and the most responsible physician must be consulted prior to discontinuation of isolation precautions for patients who test positive for COVID-19.

Patients whose COVID-19 results return negative, are to be reviewed with the physician. Physicians may wish to order repeat testing for patients with highly probably COVID-19. Repeat testing should be completed at least 48h from first test, and at least 5 days from symptoms onset (so if first test done on Day 1 of symptoms, patient should remain isolated, and repeat testing on Day 5).

Many patients may be de-escalated after one negative test, after the MRP gives clearance for de-escalation, as long as patient does not exhibit symptoms requiring ongoing isolation (ex. fever, diarrhea, vomiting etc). Patients who have had an exposure to COVID-19, or who have travelled internationally must remain in isolation to complete their 14 day isolation period, as well as meeting the above criteria for discontinuation of isolation.

If there are questions regarding isolation requirements IPAC must be contacted prior to discontinuation of isolation.

**Personal Protective Equipment**

Staff are to wear a procedure/surgical mask at all time when inside the work place, unless removed to drink or eat in a non-patient care area where physical distancing is being observed (fabric/non-medical masks allowed for staff not working in patient care areas who are able to maintain a 2m distance from others at all times). Eye protection is to be worn at all times while in patient care areas. In addition to masks, gowns and gloves are to be worn when in the room, or within 2m of patients under investigation for, or confirmed positive for COVID-19. Please see below for further direction on mask, eye protection and gown usage.

 **Masks**

* Staff are to wear a procedure/surgical mask at all time when inside the work place, unless removed to drink or eat in a non-patient care area where physical distancing is being observed.
* Patient facing staff may choose between level 1 -3 masks. Non-patient facing staff should utilize the level 1 masks provided.
* Masks should be worn for the duration of the work shift unless it becomes soiled or wet, in which case it should be changed, with an effort to use no more than 4 masks within a 12 hour period (extended use).
* Staff working directly with patients should leave the mask on at all times and not donn and doff the same mask due to increased risk of contamination. Staff working in non-patient care areas, or working in a patient care area, but not directly interacting with patients may follow limited re-use practices, doff their mask and set in a clean area, and reapply the same mask.
* If an N95 is indicated due to an aerosolizing procedure the surgical mask should be doffed and discarded and replaced by an N95. The N95 should then be left on and continue to be worn for extended use to conserve PPE and prevent ongoing switching between mask types
* The mask must be changed to an N95 respirator for any AGMP, as well as when entering the room where the AGMP occurred for the designated air exchange period (typically 1h, unless indicated as a faster time on the door). Regulated health professionals are to complete a point of care risk assessment (PCRA) prior to every patient interaction, and should assess the task, patient and environment, and may choose to use an N95 respirator as they determine required.
* Surgical masks can be worn when collecting nasopharyngeal and oropharyngeal swabs for COVID-19 testing

**Eye Protection**

* Eye protection must be worn when in any patient care area (face shield, goggles or safety glasses –not personal eye glasses).
* Full face shields are the preferable choice, as they offer a second barrier of protection and helps with the conservation of surgical/procedure masks or N-95 respirators as they are less likely to be contaminated during patient encounters

**Gowns/Tyvek**

* Patients under investigation (PUI) for, or confirmed positive for COVID-19 are on Droplet + Contact Precautions; and gowns must be worn when in their room and/or within 2m of them.
* The gowns currently available in our hospitals for care of a COVID-19 patient are adequate to protect the healthcare worker. Level 1 yellow washable gowns can be safely worn during most interactions. Level 2 washable gowns should be worn when doing activities with possible mod-large splash. Level 2 disposable blue gowns or Tyvek can be worn when intubating or doing other higher exposure risk activities (but washable gowns are adequate protection) .
* Gowns are to be changed between each patient. If the hospital pandemic plan moves into phase 3, this will be communicated to all staff. During phase 3, the same gown can be worn when caring for positive COVID-19 patients cohorted in the same room or on an entire COVID unit. This allows the healthcare worker to complete their tasks efficiently and avoid the risk of contamination by doffing less frequently
* If a COVID-19 patient is not cohorted in a COVID-19 unit, gowns and gloves must be discarded before leaving the room
* Gowns need to be removed (doffed) and hand hygiene performed between COVID-19 patients except on dedicated COVID-19 units (see upcoming slides)
* If the gown becomes visibly soiled or torn, please exit the room or the unit and remove and discard as per usual practices
* Tyvek suits may be used during high-risk procedures as per PCRA. Tyvek is **NOT** required for any procedure/situation, and gowns may be used in place of this based upon worker discretion.

**Visitors**

Visiting guidelines will be reassessed on a regular basis throughout the pandemic in order to balance the infection control risks and patient experience/needs. Updated visitor guidelines will be communicated with staff and patients. Essential caregivers will be designated distinctly from general visitors, and recognized as an important care partner during the patient visit. Visitors will be required to wear, and provide their own mask, for entry. Proper hand hygiene, 2m physical distancing, and wearing mask at all times will be communicated to visitors.

*Emergency Department and Outpatient Services*

* An essential caregiver will be allowed for patients who require their presence (ex. Children, those with disabilities, etc.), as well as essential visitors for those who require based upon their visit type (ex. Mental health, life-threatening condition, etc).
* Please note, visitors of patients who have failed screening must remain with the patient all times, as if they also require droplet/contact precautions.

*Inpatient units*

* One designated essential caregiver per patient per day, to be designated by the patient. For palliative patients, when PPS is <20, additional visitors will be permitted in consultation with the care team.
* For admitted patients who are under investigation for COVID, visitors will not be allowed until results return.
* Patients who test positive for COVID-19 will not be allowed visitors, except in extenuating circumstances (ex. child, patient with dementia, end of life, etc.).
* If a visitor is allowed for a patient with COVID-19, they must be shown how to appropriately don PPE, and wear full PPE (mask, eye protection, gown and gloves) while in the room, and must remain in the room at all times.
* Visitors must comply with public health guidelines and the hospital is not permitted to make concessions to allow visitors that would contravene what the health unit has directed
(ex. a spouse of a positive patient who was a close contact of the positive patient and has been directed to self-isolate for 14 days).  An exception would need to be approved by the Medical Officer of Health for someone who has been directed to self-isolate to break isolation and visit the hospital.

**Cleaning of Patient Rooms and Common Areas**

An enhanced cleaning schedule of common areas will be used throughout the pandemic and will vary based upon phase and requirements of the pandemic.

Rooms should be maintained will minimal clutter and furniture (ex. No magazines, brochures, openly stored items, extra chairs etc), in order to decrease infection control risks, and reduce housekeeping time to clean.

Inpatient rooms will be cleaned as per routine.

Housekeeping shall clean the Emergency Department rooms and/or other outpatient rooms when any of the below have been met:

* When the patient has spent significant time in the space (ex. Overnight, or multiple hour visit)
* There has been a significant event soiling the room/visibly soiled
* The patient has been in the room unmasked who screened positive
* The patient has screened positive and has been left in the room for a length of time unsupervised, so immediate environment/contact with surface cannot be guaranteed (ie. If a patient is brought to a room, and assessed with the clinician and discharged, the patient’s immediate environment/touched surfaces only would need to be cleaned)

Clinical staff are responsible for the following cleaning between patients:

* Wiping down any equipment used between patients (ex. BP cuff, vitals machine, physio equipment)
* Wiping down chair after patient use (ex. Patient brought into exam room for brief visit and used chair only, or patient sitting in hallway chair etc.)

**Employee Illness**

Employees are to self-monitor for symptoms, and report any new symptoms consistent with COVID-19 to occupational health prior to reporting to work. If an employee reports to work, but then fails screening at the door, they must contact their manager and Occupational Health and Safety (519-376-2121 ext. 2226). Symptoms will be reviewed with employee, and direction for COVID-19 testing and/or any additional requirement to be met for return to work will be given.

NOTE: A household or other close contact who has developed symptoms, or a household/close contact notified they are a close contact of someone who has COVID-19 does not make the employee ineligible to work, as long as the employee themselves does not have symptoms, or is not a contact of a confirmed case. If an employee has been told by Public Health that they are required to self-isolate, occupational health must be contacted to review, and the employee should not report to work unless directed otherwise by OHS.

If an employee feels they have been exposed to COVID-19 while at work (without appropriate PPE), they should consult Occupational Health to Review.

**REFERENCES**

Public Health Ontario COVID-19 labstract. <https://www.publichealthontario.ca/en/laboratory-services/test-information-index/covid-19>

Public Health Ontario – Medical Isolation Gowns for COVID-19 in Healthcare Settings (August 2020).

<https://www.publichealthontario.ca/-/media/documents/ncov/ipac/2020/08/covid-19-medical-isolation-gowns-healthcare.pdf?la=en>

Public health Ontario – IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 (July 29 2020) <https://www.publichealthontario.ca/-/media/documents/ncov/updated-ipac-measures-covid-19.pdf?la=en>

Ministry of Health COVID-19 Provincial Testing Guidance Update (Spet 24 2020). [file:///N:/Infection%20Control/COVID-19/COVID%2019%20guidance%20documents/MOH%202019\_testing\_guidance-sept%2024%202020.pdf](file:///N%3A/Infection%20Control/COVID-19/COVID%2019%20guidance%20documents/MOH%202019_testing_guidance-sept%2024%202020.pdf)

Ministry of Health COVID-19 Quick Reference Public Health Guidance and Clearance Document (October 1 2020) [file:///N:/Infection%20Control/COVID-19/COVID%2019%20guidance%20documents/MOH2019\_testing\_clearing\_cases\_guidance-oct12020.pdf](file:///N%3A/Infection%20Control/COVID-19/COVID%2019%20guidance%20documents/MOH2019_testing_clearing_cases_guidance-oct12020.pdf)

**Appendix A**

List of aerosol-generating medical procedures (AGMP), adapted from the Toronto Region Hospital Operations Committee’s “IPAC Consensus List of Aerosol-Generating Medical Procedures (AGMP)” from Ontario Health Guideline (august 11 2020),

**The following are considered AGMPs:**

* Intubation
* Extubation
* Cardiopulmonary resuscitation (note: chest compressions and cardioversion/defibrillation are not considered AGMP; however, procedures associated with CPR, such as emergent intubation and manual ventilation are)
* Noninvasive positive-pressure ventilation (e.g., CPAP, BiPAP)
* Manual ventilation
* High-flow oxygen (i.e., AIRVO, Optiflow, > 5L oxygen by nasal prongs)
* Open suctioning (e.g., “deep” insertion for nasopharyngeal or tracheal suctioning, not inclusive of oral suction)
* Bronchoscopy
* Induced sputum (e.g., inhalation of nebulized saline solution to liquify and produce airway secretions, not natural coughing to bring up sputum)
* Large-volume nebulizers for humidity
* Autopsy
* Nasopharyngoscopy
* Oral, pharyngeal, transphenoidal, and airway surgeries (including thoracic surgery and tracheostomy insertion)
* High-frequency oscillation ventilation
* Needle thoracotomy

The following are NOT considered AGMPs. This list has been adapted from Public Health Ontario’s guidance related to aerosol generation from coughs and sneezes (April 14, 2020), and updated in August 11 2020 Ontario Health Document.

**The following are NOT considered AGMPs:**

* Collection of nasopharyngeal or throat swab
* Ventilator circuit disconnect
* Chest compressions (Note: Cardiopulmonary resuscitation is considered a high-risk procedure and should only be embarked upon where there is a reasonable prospect of success)
* Chest-tube removal or insertion (unless in a setting of emergent insertion for ruptured lung/pneumothorax)
* Coughing, expectorated sputum
* Oral suctioning
* Oral hygiene
* Gastroscopy or colonoscopy
* Laparoscopy (gastrointestinal/pelvic)
* Endoscopic retrograde cholangiopancreatography
* Cardiac stress tests
* Caesarian section or vaginal delivery of baby using regional anesthesia
* Any procedure performed using regional anesthesia
* Electroconvulsive therapy
* Transesophageal echocardiogram
* Nasogastric/nasojejunal/gastrostomy/gastrojejunostomy/jejunostomy tube insertion
* Bronchial artery embolization
* Chest physiotherapy (outside of breath stacking)
* Oxygen delivered at less than or equal to 6 litres per minute by nasal prongs and less than or equal to 15 litres per minute by Venturi masks and non-rebreather masks
* Intranasal medication administration, such as naloxone