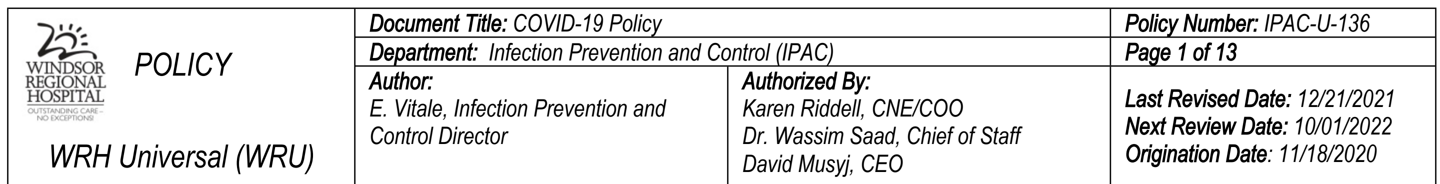


COVID-19

CONTENTS

POLICY 2

PURPOSE 2

SCOPE 2

DEFINITIONS 2

PROCESS: 2

1. Risk Factors 2
2. Screening 3

Positive Staff Screen 3

Positive Patient Screen 3

Positive Visitor Screen 3

3. Signs and Symptoms 4
4. Transmission 4
5. Diagnosis / Testing 5

Testing on Admission 5

Testing on Discharge 6

6. Duration of Additional Precautions 6

COVID-19 Positive Patients 6

7. High Risk Procedures 7
8. Communications 7
9. Staff 7
10. Special Considerations / High Risk Areas 7

Care Requirements 7

Intensive Care Unit (ICU) 8

Emergency Department 8

Operating Room 8

Paediatrics / Perinatal 8

Passes and Leave of Absence 8

Patients with a Tracheostomy (Non-Vented) 9

Patients on Oxygen, High Flow Nasal Oxygen (optiflow/airvo/opti-trach) and Nocturnal CPAP/BIPAP 9

Non-Invasive Ventilation BIPAP/CPAP 10

Care of Patient After Death 10

REFERENCES: 11

Appendix A: Placement for COVID Patients 12

POLICY:

Enhanced Droplet and Contact Precautions are to be used by all Windsor Regional Hospital (WRH) staff in addition to Routine Practices for all **suspected** and **confirmed** COVID-19 patients.

Refer to policy "**COVID-19 Universal Precautions**", for information on accommodation, personal protective equipment, aerosol generating medical procedures, environment and equipment cleaning, transport, patient mobility and visitors. For more information on Routine Practices refer to the policy.

PURPOSE:

To outline procedures for the management of patients with known or suspected COVID-19 infection.

SCOPE:

This policy applies to:

- All WRH staff, professional staff and learners who recognize the signs and symptoms of COVID-19 infection and those patients considered at high risk for COVID-19 infection.
- All WRH staff, professional staff, learners and affiliates involved in the care, or entering the room, of a patient with known or suspected COVID-19 infection.

DEFINITIONS:

Enhanced Droplet and Contact Precautions: Used in addition to Routine Practices for patients known or suspected of having an infection that can be transmitted by large infectious droplets, contact with an infectious person, and potentially through the generation of aerosolized particles during certain procedures. Staff must wear a gown, gloves, mask and eye protection, and the patient must be placed in a room by themselves, or if the patient has been confirmed to have COVID-19, then they may be cohorted with other confirmed cases of COVID-19. Staff are to use an N95 respirator when performing aerosol generating medical procedures (AGMP), and for prolonged care activities for suspected and confirmed COVID-19 cases. Refer to policy on **COVID-19 Universal Precautions**.

Close contact: as a person who had a high-risk exposure to a confirmed or probable case during their period of communicability. This includes household, community and healthcare exposures as outlined in Ministry guidance on cases and contacts of COVID-19.

PROCESS:

All WRH staff, and professional staff, are responsible for following the practice guidelines below when managing a patient with known or suspected COVID-19 infection. Compliance is monitored by the unit Managers, and the Infection Prevention and Control (IPAC) Department, and reported to the Program Directors, VPs, and Chiefs.

1. Risk Factors

The greatest risk factors for acquisition of COVID-19 are the following:

- Close contact with a confirmed case of COVID-19.
- Living in or working in a facility known to be experiencing an outbreak of COVID-19 (e.g., long-term care, rest home, prison).
- Travel to an affected area (including inside of Canada) in the 14 days prior to symptom onset. Affected areas are updated regularly in the World Health Organization's Situation Reports. Current epidemiology in Canada is available through the Public Health Agency of Canada.

There are also cases reported with no known epidemiological link that are likely related to community spread of COVID-19. Refer to the Public Health Agency of Canada or the COVID-19: Epidemiologic summaries from Public Health Ontario for specific percentages of cases with no known epidemiological link.

2. Screening

All patients, visitors, staff, affiliates, and volunteers must be screened for the typical and atypical signs and symptoms of COVID-19 on presentation to the healthcare facility.

Patients and visitors are screened using the VISITOR / PATIENT COVID-19 SCREENING FORM or the MESH mobile application.

All staff are screened using the STAFF COVID-19 SCREENING FORM or the MESH mobile application.

When the decision to admit is made all patients are screened using the COVID Assessment Form. For any patient meeting criteria, **Enhanced Droplet and Contact Precautions** are initiated and the patient is tested for COVID-19 on admission.

Positive Staff Screen

If a staff member answers yes to any of the screening questions, ideally they should not arrive at work. However, if they are identified at screening, they are not to leave the entrance area, and must contact Employee Health immediately for assessment. Met Campus ext. 52588, and Ouellette Campus ext. 32525.

Positive Patient Screen

If a patient answers yes to any of the screening questions, the patient must remain separated from others. The screener is to notify the receiving department that the patient is a positive screen.

Positive Visitor Screen

For visitors who answer yes to any of the screening question, the screener must review the form and may be required to obtain more information.

If a visitor answers **yes to any of the symptoms of COVID-19 listed, then they are not permitted to enter the facility – there are no exceptions**.

If a visitor answers yes to travel outside of Canada in the last 14 days and is an essential worker in the United States, then they may visit provided that they are asymptomatic, maintain 2 meter spatial separation, and wear a mask. Essential workers that live in Canada but work in the United States are exempt from the mandatory 14 day quarantine requirement for travelers entering Canada. There are limited exemption from border restrictions and limited release from quarantine exceptions for compassionate reasons. Individuals must apply for exemption through the Public Health Agency of Canada, which includes a Letter of Required Support from the facility the individual will be visiting. Individuals meeting this criteria will be placed on the approved visitation list by the Patient Representatives, once approved through the appeals committee.

If a visitor answers yes to testing positive for COVID-19 or having close contact with a confirmed case of COVID-19, then they may visit if they are asymptomatic and the date of the positive test, or last date of contact, was more than 14 days ago. Screeners must escalate to Infection Prevention and Control or the After Hours Administrator for review.

Consult Infection Prevention and Control for further direction as needed.

3. Signs and Symptoms

Typical Signs & Symptoms

- Fever (temperature of 37.8°C or greater)
- New or worsening cough
- Shortness of breath (dyspnea)
- Sore throat
- Difficulty swallowing
- New olfactory or taste disorder(s)
- Nausea/vomiting, diarrhea, abdominal pain
- Runny nose, or nasal congestion – in absence of underlying reason (e.g. seasonal allergies, post nasal drip)
- Clinical or radiological evidence of pneumonia

Atypical Symptoms/Signs of COVID-19

Atypical presentations of COVID-19 should be considered, particularly in children, older persons and people living with a developmental disability.

Symptoms
- Unexplained fatigue/malaise/myalgias
- Delirium (acutely altered mental status and inattention)
- Unexplained or increased number of falls
- Acute functional decline
- Exacerbation of chronic conditions
- Chills
- Headaches
- Croup
- Conjunctivitis
- Multisystem inflammatory vasculitis in children

Signs
- Unexplained tachycardia, including age specific tachycardia for children
- Decrease in blood pressure
- Unexplained hypoxia (even if mild i.e. O_2 sat less than 90%)
- Lethargy, difficulty feeding in infants (if no other diagnosis)

4. Transmission

The predominant mode of transmission of COVID-19 is via respiratory droplets during close unprotected contact. Airborne spread has not been a dominant or common mode of transmission, and is only a concern in poorly ventilated crowded spaces. Aerosols may be generated during aerosol generating medical procedures (AGMPs), which may increase the risk of transmission.

Transmission through the ocular surface is considered a possible route of transmission for COVID-19.

COVID-19 can survive on surfaces and may be transmitted via fomites. The extent that fomites contribute to transmission is unknown.

COVID-19 has been detected in stool and blood, however the roles of fecal-oral and blood borne transmission remain uncertain.

5. Diagnosis / Testing

There are two primary methods used in Ontario for COVID-19 testing:

1. PCR testing (also known as polymerase chain reaction testing), is a type of test that detects the genetic material of the virus to identify those individuals that **currently have COVID-19**. It uses a sample collected with a swab from the person's nasopharyngeal area, nose or throat. Individuals that have tested positive for COVID-19 with or without symptoms can test positive by PCR for weeks to months after the initial positive test.

2. Serology testing tests someone's blood to see if they have antibodies for COVID-19. This primarily tells us if someone **previously had COVID-19**. Currently this test is used in limited clinical situations.

3. Rapid Antigen Screening quickly detect fragments of proteins found on or within the virus by testing samples collected from nasopharyngeal swabs, and can provide results within 15 minutes. Rapid antigen testing is used for screening purposes only and should NOT be used for diagnosis of acute COVID-19 infection.

Specific information about COVID-19 testing in Ontario can be found at the following link to Public Health Ontario Laboratories COVID-19 testing: https://www.publichealthontario.ca/en/laboratory-services/test-information-index/covid-19

For PCR testing the following specimens are recommended (in order of preference):

1. Nasopharyngeal swab (gold standard) (preferred for inpatients)
2. Combined swab of throat and both nostrils (acceptable for inpatients)
3. Combined oral and deep nasal swab (not appropriate for inpatients)

5.1 Testing on Admission

Any patient presenting with at least one sign or symptom of COVID-19 must be tested using PCR methodology (refer to section 3. Signs and Symptoms).

The following groups should be tested – **even if asymptomatic**:

- Contacts of confirmed positive cases
- All residents admitted from another hospital, Long Term Care (LTC), Retirement Home or Rest Home, or other congregate living settings and institutions*
- Newborns of suspected or known COVID-19 (within 24 hours of delivery, and again at 48 hours of life)
- Elective pre-operative patients undergoing general anesthesia (tested 4 days prior to date of surgery) when the COVID-19 prevalence in the community is considered "**not low**" or greater than 20 per 100,000 population. **A notification of the need to resume pre-operative COVID-19 testing will be distributed when the prevalence in community is considered not low.**
- For pre-operative patients that are tested prior to surgery, the pre-operative swab done in the assessment center counts as the day 1 swab.
- Any patient where there is some concern regarding COVID-19. Due to the high community numbers in Windsor-Essex County all patients are tested on admission and on day 5.

All patients who are ventilated or require noninvasive ventilation regardless of etiology should be tested for COVID-19.

Patients that refuse testing must remain in **Enhanced Droplet and Contact Precautions** for the duration of their stay, until tested and negative, or for 10 days from admission (whichever comes first). Consider combined throat and both nostrils cultures, if the nasopharyngeal swab is specifically being refused.

5.2 Testing on Discharge

The following groups must be tested prior to discharge from the hospital:

- LTC, Retirement Home (results must be negative and received within 24 hours of transfer)
- Asymptomatic patients being transferred to hospice (results must be negative prior to transfer)
- Patients entering a residential mental health or addiction program, including those patients being admitted to Mental Health Services at HDGH

Any patient who has previously tested positive for COVID-19 and have since recovered does NOT need to be tested prior to or after transfer between facilities.

6. Duration of Additional Precautions

6.1 Initiation:

- Enhanced Droplet and Contact Precautions must be initiated as soon as signs and symptoms of COVID-19 are identified, and on admission for patients that are asymptomatic and being tested based on guidance listed above.
- Due to low incidence of COVID-19 in hospital, patients that are being tested for COVID-19 as a result of transfer between Met and Ouellette Campuses do not require Enhanced Droplet and Contact precautions unless they are a transfer from an outbreak unit.

6.2 Discontinuation:

COVID-19 Negative Patients

- Continue Enhanced Droplet Contact Precautions, even after COVID-19 has been ruled out, in order to ensure that precautions are in place for a sufficient time for other respiratory infections (e.g. influenza, RSV). **Infection Prevention and Control must be consulted prior to discontinuing Droplet and Contact Precautions in patients that have a negative COVID-19 test result.**

COVID-19 Positive Patients

- All cases may be cleared by a non-test based approach.

- COVID-19 positive patients are considered resolved (passed the communicability period or no longer infectious) at 10 days after symptom onset (or 10 days from when swab was taken if persistently asymptomatic) provided that the individual is afebrile and symptoms are improving for at least 24 hours. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.

- COVID-19 positive patients with **severe illness** (requiring ICU level of care) or severe immune compromise (undergoing cancer chemotherapy, untreated HIV infection are considered resolved (passed the communicability period no longer infectious) at 20 days after symptom onset (or 20 days from when swab was taken if persistently asymptomatic) provided that the individual is afebrile and symptoms are improving for at least 24 hours. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. Factors such as advanced age, diabetes and end-stage renal disease are generally not considered severe immune compromise.

- **Infection Prevention and Control <u>must</u> be consulted prior to discontinuing Enhanced Droplet and Contact Precautions for confirmed positive COVID-19 patients.**

7. High Risk Procedures

High hazard procedures where COVID-19 may be aerosolized, require special precautions to prevent/minimize occupational exposure to infectious COVID-19. The following are high-hazard procedures where (in theory) transmission of COVID-19 may be possible:

- Intubation, extubation and related procedures e.g. manual ventilation and open suctioning
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
- Bronchoscopy
- Surgeries*using high speed devices in the respiratory tract
- Post-mortem procedures involving high-speed devices
- Certain dental procedures e.g., high-speed drilling and ultrasonic cleaning
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure ventilation (CPAP)
- High-Frequency Oscillating Ventilation (HFOV)
- Induction of sputum with nebulized saline
- High flow nasal oxygen (high flow nasal cannula therapy >6 liters)

  *Specifically for acute respiratory infections this pertains to surgery involving high speed devices in the respiratory tract.

Experts presume that transmission is possible through aerosols when these procedures are performed on COVID-19 patients. For a full list of aerosol generating medical procedures, refer to the **COVID-19 Universal Precautions** policy.

8. Communications

Effective communication regarding Additional Precautions, is essential when a patient goes to another department for testing, to another unit or to other healthcare settings or facilities. This communication must include Emergency Medical Services (EMS) staff, patients, families, other departments, other facilities and transport services prior to transfer and other transport staff.

9. Staff

Employee Health is responsible for the screening and surveillance of healthcare workers for COVID-19.

HCWs with acute respiratory infections should refrain from patient care activities, particularly during the first few days of illness when communicability is highest, and report to Employee Health prior to returning to work.

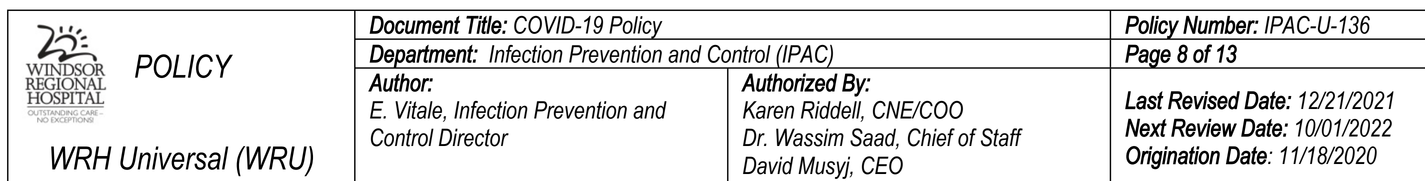
Refer to COVID-19 Employee Protocol.

10. Special Considerations / High Risk Areas

10.1 Care Requirements

The following items must be considered during the care of a suspected or known COVID-19 patient:

- Avoid aerosol generating procedures.
- If an AGMP must be performed then the patient should ideally be in a room by themselves.
- Avoid nebulized treatment.
  - Contact pharmacy or respiratory care to auto-sub any aerosols.
  - If MDI is inappropriate based on clinical status of the patient (i.e. patient unable to take a deep inspiration), or if the patient is less than 5 years of age and unable to manage MDI aerosol, then the patient must remain in a room by themselves.
    - If COVID-19 negative may use nebulizers and humidified O_2.
- Cluster care to reduce the number of times the room must be entered



- Consider adjusting the timing of lab work, medication administration times, vital signs and intake / output, infusion checks and other direct patient care activities.
- Work with pharmacy and lab as needed.
- Avoid routine daily chest x-rays if not needed.

10.2 Intensive Care Unit (ICU)

For patients admitted to ICU with a low suspicion of COVID-19 (as determined by the MRP), a negative swab on admission and on day 5 may be used to rule out COVID-19 infection.

For patients admitted to the ICU with a high clinical suspicion for COVID-19 (as determined by the MRP, or patient risk factors), a negative swab on admission and on day 5 is required, and at least 1 endotracheal aspirate or sputum sample is required.

CCOT should be activated for any suspect or confirmed COVID-19 patient exhibiting signs of clinical deterioration or respiratory distress / fatigue or increasing oxygen requirements to maintain saturations.

Refer to Code Blue procedures for more detail on the Code Blue process during the COVID-19 pandemic.

10.3 Emergency Department

Emergency room staff shall assess the patient and the need for testing using the COVID Assessment Form when the decision to admit is made.

10.4 Operating Room

When COVID-19 prevalence in the community is considered “not low” or greater than 20 per 100,000 population, elective patients undergoing general anesthesia are to be tested for COVID-19 approximately 4 days prior to the procedure. A notification of the need to resume pre-operative COVID-19 testing will be distributed when the prevalence in community is considered not low. COVID-19 results obtained greater than 4 days prior to procedure may not be valid, as the patient could be exposed and acquire COVID-19 during the date of collection of the swab to the date of procedure.

All patients having surgery must be assessed using the COVID-19 Operating Room Assessment Form.

If the patient screens negative (or tests negative) and is considered low risk, then the surgical procedure may proceed and wait time for air clearance following extubation is not required.

If a patient is considered high risk (due to screening positive, recent exposure or test results), the procedure may be postponed, or may proceed based on MRP assessment, and include a 15 minute post extubation wait time for air clearance in the operating room.

10.5 Paediatrics / Perinatal

In paediatrics, there is 1 visitor allowed to remain with the suspected or confirmed COVID-19 patient (typically the parent who has been exposed within the household). The visitor must remain in the room with the patient and is not allowed to leave the unit and visit public spaces.

10.6 Passes and Leave of Absence

Patients may leave the hospital's property for a short stay absence for health care-related reasons. A short stay absence does not include an overnight stay. Upon return to the hospital, patients must be actively screened but are not required to be tested again or self-isolate.

Patients must be provided with a medical mask to be worn at all times when outside of the hospital (if tolerated) and be reminded about the importance of public health measures including masking, hand hygiene, and physical distancing.

10.7 Patients with a Tracheostomy (Non-Vented)

For all tracheostomy patients:

- A private room or room by themselves is required, due to the risk of frequent AGMP, and hospital acquisition of COVID-19 infection.
  - Trached patients that are considered resolved COVID-19 may be cohorted together.
- Humidity may be used as normal.
- Assess patient for bronchodilator need.
- Substitute MDI with aero-chamber for aerosols.
- The door must be closed for suctioning the airway and tracheostomy.
- For COVID-19 confirmed cases - suctioning the airway is to be done using an in-line suction setup (RT will setup).

10.8 Patients on Oxygen, High Flow Nasal Oxygen (optiflow/airvo/opti-trach) and Nocturnal CPAP/BIPAP

- Refer to COVID-19 Universal Precautions policy for a list of examples of AGMP

Respiratory Aerosol Medication

- Substitute breathing treatments with an MDI with an aerochamber.
- Assess the need for breathing treatment.
- Refer to Care Requirements section.

Oxygen

- **Nasal prongs** titrate to a maximum flow rate of 5 LPM. Apply a surgical mask over mouth and nose over O_2 device, if tolerated, when outside of the patient's bedspace.
- **Venti-mask** is used up to 50% FiO_2 with a surgical mask over the mask, if tolerated, when outside of the patient's bedspace.
- **Non-rebreather mask** (NRM) is used if clinically indicated for FiO_2 greater than 50% with a surgical mask over the O_2 mask, use NRM with an exhalation filter if available.
- For suspect or confirmed COVID-19 oxygen should be delivered without added humidity.
- **CCOT and RT should be consulted if FiO_2 requirements increase e.g. 6 LPM nasal cannula OR FiO_2 40% venti mask.**

High Flow Nasal Oxygen (HFNO)

- Apply a surgical mask over the O_2 device until the patient is in appropriate accommodation.
- CCOT team should be consulted prior upon institution of high flow device.

Nocturnal CPAP/BiPAP

- MRP should assess whether the patient's NIV can be held without significant short term patient harm.
  - e.g. CPAP for OSA where the patient is not getting narcotics, or where the patient is getting narcotics but their oxygenation is being continuously monitored may be able to be held. Conversely, a patient using NIV for severe neuromuscular disease associated respiratory failure may not be able to avoid using their home device.
  - Respirology or ICU consultation can be considered if there is uncertainty.

- Patients who need their NIV device should have an NP swab sent for COVID-19 even if they are asymptomatic given the risk of aerosolization, or consider the use of overnight oximetry. Ensure door is closed when NIV is in use.
- **A positive COVID-19 swab should lead to reassessment of NIV** unless this would result in significant patient demise in which case risk/benefit of NIV will need to be reassessed.
- **If the patient's COVID-19 swab is negative** NIV can be continued, but a private room or room by themselves is required, due to the risk of frequent AGMP, and hospital acquisition of COVID-19 infection.

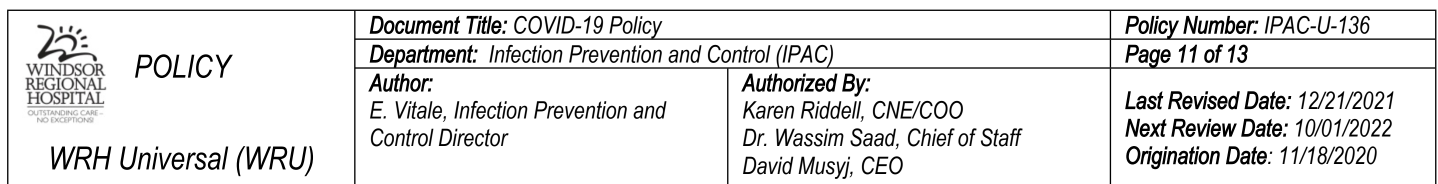
10.9 Non-Invasive Ventilation BIPAP/CPAP

The following principles should be followed when considering use of NIV with consideration of the precautions required for COVID-19:

1. Consideration of using Non-Invasive Ventilation (NIV) for acute deterioration **always** requires an **intensivist consultation**. NIV may result in aerosolization of respiratory secretions, therefore the benefit in using should always outweigh the risk.
2. In patients with respiratory failure due to CHF, and in some patients with hypercapneic respiratory failure, NIV may be of benefit and should be initiated on a case by case basis after discussion with the intensivist on call.
    a. A full Goals of Care conversation needs to be had with the patient or substitute decision maker **prior to initiation of BIPAP**.
    b. A nasopharyngeal swab to rule out COVID-19 is required. Further action based on the following results:
        i. For a **negative COVID-19 results with low clinical suspicion for COVID-19 (low risk of false negative result):** The patient may be placed in a a private room or room by themselves is required, due to the risk of frequent AGMP, and hospital acquisition of COVID-19 infection.
        ii. For a **positive COVID-19 result:** NIV is not recommended. Alternatives would include invasive ventilation or readdressing GOC and initiating palliative care discussions. Must remain in enhanced precautions.
    c. A patient still requiring NIV after 7 days of admission, should have their need for NIV re-assessed as most indications for NIV are typically short term.
3. NIV is not recommended for patients with hypoxemic respiratory failure due to COVID. It is associated with high failure rates in this population and should not be used.

10.10 Care of Patient After Death

For suspected or confirmed COVID-19 cases, maintain same precautions as prior to death. Refer to policy Death of a Patient – Deceased Patient Care Handling During COVID-19 Pandemic.



REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology. (2018). *APIC Text of Infection Control & Epidemiology* (online ed.). Washington, DC
2. Provincial Infectious Disease Advisory Committee (2012). *Routine Practices and Additional Precautions in All Health Care Settings*. Ontario Agency for Health Protection and Promotion, Public Health Ontario. Retrieved November 20th, 2013 from: http://www.publichealthontario.ca/en/eRepository/RPAP_All_Health care_Settings_Eng2012.pdf
3. Public Health Ontario (2020). IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19. Retrieved October 14th, 2020 from: https://www.publichealthontario.ca/-/media/documents/ncov/updated-ipac-measures-covid-19.pdf?la=en
4. Public Health Ontario (2020). Synopsis: COVID-19 Routes of Transmission – What We Know So Far. Retrieved October 10th, 2020 from: https://www.publichealthontario.ca/-/media/documents/ncov/wwksf-routes-transmission-mar-06-2020.pdf?la=en
5. Ministry of Health and Long Term Care (2020). COVID-19 Provincial Testing Guidance Update May 24th, 2020. Retrieved June 2nd, 2020 from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_guidance.pdf
6. Public Health Ontario (2020). Focus on COVID-19: Aerosol Generation from Coughs and Sneezes. Retrieved October 10th, 2020 from: https://www.publichealthontario.ca/-/media/documents/ncov/ipac/report-covid-19-aerosol-generation-coughs-sneezes.pdf?la=en
7. Government of Canada – Public Safety Canada (2020). Guidance on Essential Services and Functions in Canada During the COVID-19 Pandemic. Retrieved October 10th, 2020 from https://www.publicsafety.gc.ca/cnt/ntnl-scrt/crtcl-nfrstrctr/esf-sfe-en.aspx
8. Government of Canada (2020). Coronavirus disease (COVID-19): Travel Restrictions, Exemptions and Advice. Retrieved October 10th, 2020 from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/latest-travel-health-advice.html
9. World Health Organization (2020). Infection Prevention and Control during Health Care when Coronavirus Disease (COVID-19) is Suspected or Confirmed. Retrieved October 10th , 2020 from: https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-2020.4
10. Government of Canada (2020). COVID-19: Compassionate entry for travellers and limited release from quarantine. Retrieved October 14th, 2020 from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/latest-travel-health-advice/compassionate-entry-limited-release-from-quarantine.html#step2
11. Siegel, J., Rhinehart, E., Jackson, M., Chiarello, L., and the Health care Infection Control Practices Advisory Committee (2007). *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Health care Settings*. Health care Infection Control Practices Advisory Committee. Retrieved November 20th, 2013 from: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
12. (1990). *Occupational health and safety act, r.s.o.*. Retrieved August19th, 2015 from Service Ontario website: http://www.ontario.ca/Laws
13. (2006). *Pocket Ontario oh&s act & regulations. consolidated edition*. Toronto, ON: Thomson Carswell.

Appendix A: Placement for COVID Patients

Placement for Suspect, Confirmed and Resolved COVID-19

At Met Campus suspected or confirmed COVID-19 patients should primarily be placed on 4N, 5N, 6N, 7N. Patients that are low risk with very low suspicion for COVID-19 should primarily be placed on 4W and 8N.

At Ouellette Campus suspected or confirmed COVID-19 patients should primarily be placed on CTU, 7W, 2N, 6E. Patients that are low risk with very low suspicion for COVID-19 should primarily be placed on 6W, 8E, and 8W.

If capacity is exceeded on COVID-19 units identified above, then suspect or confirmed cases may be placed in low risk areas in a room by themselves.

Airborne Infection Isolation Rooms (AIIR) must be reserved for airborne infections (TB, chickenpox and measles). When not in use for Airborne Infections, AIIR should ideally be reserved for suspect / confirmed COVID patients with the most AGMP required.

Cohorting

- All suspected symptomatic COVID-19 patients are to be in a room by themselves or cohorted as follows:
  - Suspected COVID-19 cases (i.e. symptomatic) or those with a high risk exposure, or from an outbreak facility – must be placed in a room by themselves or in the wards/rooms designated as acceptable, where spatial separation can be maintained (see below).
  - Suspected COVID-19 cases that are symptomatic can have PCR testing done in house, and the PCR test is negative may be cohorted with other suspected COVID-19 cases that have also tested negative, as long as there is no high risk exposure or they are from an outbreak facility.
  - Suspected COVID-19 with the same high risk exposure or from the same outbreak facility may be cohorted.
  - Patients that are low risk, asymptomatic, and only being tested due to admission may be cohorted together.
  - Confirmed COVID-19 must be cohorted with other confirmed COVID-19.
  - Resolved COVID-19 can be placed with confirmed COVID-19 or with other patients that have not had COVID-19. Resolved cases are no longer capable of spreading the infection.
- Suspect symptomatic COVID-19 patients may be cohorted in multi-bed rooms as follows:
  - Ward room with other suspected COVID-19 patient in beds that are spatially separate:
    - **At Met Campus**: Bed A and Bed C, Bed B and Bed D – ensuring that the beds are located on opposite ends of the room and diagonal to each other to maintain the most spatial separation possible.
    - **At Ouellette Campus**: in order of priority: 560 A & C, 542 A & B, 543 A & C, 564 A & C, 565 A & C
    - Toileting must be dedicated:
      - 1 patient to use bathroom, 1 patient to used commode (use nursing discretion as to best patient for each option)
      - If patients are both ambulatory & refuse commode – nursing staff must be notified after each patient uses the bathroom to ensure a clean of high touch surfaces occurs after use
- Confirmed positive COVID-19 patients with a hard copy of their COVID-19 positive tests results available in their chart may be cohorted
- For Medical / Surgical asymptomatic suspect COVID-19 may be cohorted with approval - **escalate to Director or AHA for approval**
- For Mental Health – asymptomatic suspect COVID-19 patients can be cohorted, symptomatic must be in a private room

Appendix A: Table 1. Cohorting Guideline

Patient Type	Room by Themselves	May cohort in room with Resolved COVID	May cohort with like in ward with spatial separation	May cohort with asymptomatic rule out COVID without AGMP	May cohort with negative COVID	May cohort with confirmed COVID+
Any patient with High Risk Exposure	X - or room with patient with same exposure type					
Symptomatic suspect COVID with AGMP	X	X				
Symptomatic suspect COVID without AGMP	X	X	X			
Asymptomatic rule out COVID with AGMP	X	X				
Asymptomatic rule out COVID without AGMP	X	X	X	X	X	
COVID+ with or without AGMP	X	X				X
COVID Resolved with AGMP	X	X				X
COVID Resolved without AGMP	X	X	X	X	X	X

X = ok to cohort