COVID-19 FAQs for Hospitals

This document provides questions and answers to COVID-19 inquiries that Public Health Ontario has received from acute care facilities in Ontario to date. Where applicable, relevant updates and resources are provided.

Note that this document is current as of April 17, 2020.

This document provides responses to the following questions:

1. Should I start using disposable cutlery and dishes at our facility?

2. Will we need to use a different cleaning product for COVID-19?

3. Should we change the handling of our laundry and linen?

4. Should we be wearing N95 respirators if we are doing COVID testing at our facilities?

5. Do we need to get a more protective isolation gown?

6. Do we need to get a more protective procedural mask?

7. Should we be disposing of PPE used for caring for a patient with COVID-19 into bio-hazardous waste?

8. Is it okay to use re-fillable soap or ABHR containers if we run out?

9. Do we need to do anything differently for disposal of used tissues if a resident has COVID-19?

10. When can a staff member who is ill with respiratory symptoms return to work?

11. Do you know the efficacy of homemade masks and if/when they should be used.

12. Are there are reprocessing guidelines in regards reprocessing N95 masks?

13. Can N95s used in care and fit testing that aren’t visibly soiled or wet be stored in a pre-labelled paper bag and re-used in the event that we get to critically low supply?

14. Our organization has received direction to consider ALL individuals requiring intubation to be completed in negative pressure. Can you provide direction on this?

15. What are the risks of contamination of paper going in and out of the room of a COVID-19 patient?

16. What are the best practice recommendations to extend the use of masks?

17. Are we allowed to accept food donations or items dropped off by families?

18. Is the PHU or the facility responsible for approving the return-to-work of staff members who have COVID-19?

19. What PPE is required for staff members working in Assessment centres?

20. How do we identify a hospital-acquired COVID-19 infection?

21. Is CPR considered an aerosol-generating medical procedure (AGMP)?

1. Should I start using disposable cutlery and dishes at our facility?

A: There is no requirement to use disposable or isolation trays for patients who are on droplet/contact precautions. In the PIDAC document for Routine Practices and Additional Precautions section for "Food preparation, dishware and eating utensils" it states that reusable dishware may be used, including for those on additional precautions (p.19).

2. Will we need to use a different cleaning product for COVID-19?

A: You likely do not need to use a different cleaning product. COVID-19 is an enveloped single-stranded RNA virus. Enveloped viruses are among the easiest pathogens to kill and are inactivated/destroyed by low level disinfectants. Therefore, a broad-spectrum virucide would be effective. The product should have (a) a DIN number, (b) stated efficacy against viruses, and (c) an appropriate contact time..

3. Should we change the handling of our laundry and linen?

A: The PIDAC Best Practices for Environmental Cleaning document identifies that routine practices for handling and laundering are sufficient, regardless of the source of the linen. It is important that all laundry and linen be handled in a manner that minimizes agitation to avoid contamination of the air, surfaces and persons. Persons handling linen and laundry should also be wearing PPE.

4. Should we be wearing N95 respirators if we are doing COVID testing at our facilities?

A: Testing for COVID-19 involves an NP swab or a viral throat swab. Neither of these is considered an aerosol-generating procedure, and therefore, a surgical/procedural mask is sufficient.

5. Do we need to get a more protective isolation gown?

A: At this point there are no specific recommendations regarding gowns. Droplet and contact precautions are deemed to be sufficient for most COVID-19 patient interactions (other than aerosol generating medical procedures). These include the use of an isolation gown, in addition to a surgical/procedure masks, gloves and eye protection. The Canadian Standards Association (CSA) classifies gowns according to one of four levels of barrier performance and advises that the choice of gown should be guided by an assessment of (a) the anticipated amount of fluid, (b) the potential for fluids splash or spray, and (c) the anticipated amount of pressure on the gown.

Refer to Annex K of CSA Z314.0-13: Medical device reprocessing- general requirements for more information on gown selection.

6. Do we need to get a more protective procedural mask?

A: There is a chart in the RPAP PIDAC document which describes different masks and uses. It doesn't describe mask levels, however. That is terminology that comes from the US ASTM Standards. That being said, when choosing PPE, staff are to conduct a Point of Care Risk Assessment of the expected interaction and choosing a mask and other PPE accordingly. Molinari and Nelson, in their article Face Mask Performance: Are You Protected? (2016) indicates the following when choosing the most correct mask, and provides some information about the ASTM levels:

- American Society of Testing and Materials (ASTM) Level 1 (low barrier) masks are designed to be used during patient care where low concentrations of spatter, fluid, or aerosols are generated.
- ASTM Level 2 masks. These are manufactured to provide a protective barrier when treatment produces moderate amounts of airborne fluid, spatter and/or aerosols.
- ASTM Level 3 masks. These single-use disposables are to be worn when heavy to moderate airborne material is produced, such as levels noted during surgical, ultrasonic scaling in dentistry, etc.

PIDAC does not reference ASTM standards and there is no reference to mask levels within the Canadian Standards (i.e., those set forth by CSA).

Refer to Appendix M, page 73, “advantages and disadvantages of PPE” of the PIDAC Best Practice document for Routine Practices and Additional Precautions for a breakdown of the types of masks.

7. Should we be disposing of PPE used for caring for a patient with COVID-19 into bio-hazardous waste?

A: Based on guidelines from PHAC, the Healthcare Waste Institute, and CDC, the current best practice is to dispose of the PPE using routine disposal protocols. As part of routine practices, according to PIDAC's Routine Practices and Additional Precautions Guideline, "Waste handlers should wear protective apparel appropriate to their risk (e.g., gloves, protective footwear)" as part of routine practices.

At this time, facilities are being asked to save their used masks and N95 respirators. There are some potentially effective PPE reprocessing techniques that may be recommended for use in the future.

8. Is it okay to use re-fillable soap or ABHR containers if we run out?

A: According to PIDAC's Best Practice Recommendations for Hand Hygiene: **"use single-use product dispensers that are discarded when empty. Do not "top-up" or refill containers. Clearly define responsibility for maintaining product dispensers."**

Before you decide to refill, for issues with supply for healthcare, please have your supply person reach out to the Ministry's HCW Hotline 1-866-212-2272 as they may have some additional options for acquiring sanitizer. Also, please inform/request assistance through EOCLogistics.moh@ontario.ca where they are tracking and prioritizing supply across the province.

9. Do we need to do anything differently for disposal of used tissues if a resident has COVID-19?

A: Waste can be disposed as per normal practices and in accordance with local by-laws. A lined, touch-free garbage receptacle is preferred.

10. When can a staff member who is ill with respiratory symptoms return to work?

A: The current direction for those who suspect they may have COVID-19 is to complete the online Ministry of Health self-assessment tool and to contact their primary care provider or Telehealth for further instruction regarding the need to visit an assessment centre.

If staff are deemed to be critical workers, and if they are asymptomatic and have either returned from recent travel or had an unprotected exposure to a person with COVID-19, then they may continue to

work while taking additional precautions when at work, and while maintaining self-isolation when not at work (see further guidance here). This should be discussed with the local public health unit.

Staff who develop symptoms are to be managed as per the following recommendations from the MOHLTC Quick reference guidance for public health unit testing and clearance:

Recommendations for Health Care Workers Return to Work

Symptoms	Test Result	Recommendations
Yes	Positive	**Test-based approach:** HCWs who have tested positive for COVID-19 should remain off work until they receive 2 consecutive negative specimens (single NP swab) at least 24 hours apart **Non test-based approach:** HCWs may return to work 14 days after symptom onset (or as directed by their employer/Occupational Health and Safety)
Yes	Negative	May return to work 24 hours after symptom resolution. If the HCW was self-isolating due to an exposure at the time of testing, return to work should be under work self-isolation until 14 days from last exposure.
Never symptomatic at time of test	Positive	**Test-based approach:** HCWs who have tested positive for COVID-19 should remain off work until they receive 2 consecutive negative specimens (single NP swab) at least 24 hours apart **Non test-based approach:** HCWs may return to work 14 days after positive specimen collection date (or as directed by their employer/Occupational Health and Safety)

- "work self-isolation" means maintaining self-isolation measures outside of work for 14 days from symptom onset (or 14 days from positive specimen collection date if asymptomatic) to avoid transmitting to household members or other community contacts. While at work, the HCW should adhere to universal masking recommendations, maintain physical distancing (>2m) except for providing direct care, and performing meticulous hand hygiene. These measures at work are required to continue until test-based or non-test based clearance.
- In exceptional circumstances where additional staff are critically required, an earlier return to work of a COVID-19 positive HCW may be considered under work self-isolation recognizing the staff may still be infectious. In the case of a positive symptomatic HCW, there should be a minimum of 72 hours after illness resolving, defined as resolution of fever and improvement in respiratory and other symptoms. In the case of a positive asymptomatic HCW, there should be a minimum of 72 hours from positive specimen collection date to ensure symptoms have not developed in that time.

11. Do you know the efficacy of homemade masks and if/when they should be used.

A: Health Canada has recently published some guidance (March 27th) specifically regarding homemade mask use in health care settings. Health Canada has also developed guidance regarding optimizing the use of masks and respirators. Currently the use of homemade PPE by healthcare workers, including masks, is not recommended in Canada.

12. Are there are reprocessing guidelines for N95 masks?

A: Currently Public Health Ontario does not currently endorse the practice of reprocessing PPE that is intended for single use. Please see here for what we know so far on the re-use and reprocessing of masks.

13. Can N95s that aren't visibly soiled or wet be stored in a pre-labelled paper bag and re-used in the event that we get to critically low supply?

A: Saving N95 masks for reuse by placing in paper bags or other methods is not a recommended IPAC practice. The risk for HCW self-contamination when donning a used mask is a serious concern. Please see here for what we know so far on the re-use and reprocessing of masks.

14. Our organization has received direction to consider ALL individuals requiring intubation to be completed in negative pressure. Can you provide direction on this?

A: The use of an AIIR is the recommended standard of care when performing an AGMP (see below). If an AIIR is not available, a single room with the door closed should be used for the procedure. See here.

15. What are the risks of contamination of paper going in and out of the room of a COVID-19 patient?

A: The PIDAC: Routine Practices and Additional Precautions in All Health Care Settings document (2012) suggests that as part of Contact and Droplet precautions, equipment and items in the environment such as "Chart (paper or mobile electronic) should not be taken into the room."

Chin et. al. (Lancet article) looked at the stability of the virus on various surfaces (glass, paper, tissue, wood, cloth, banknote) including a surgical mask by inoculating and eluting the virus at different time points, which the authors note does not necessarily reflect the potential to pick up the virus from casual contact (and get infected). Virus lasted the longest on the outside of surgical masks, (with 0.1% of the original inoculum detectable at 7 days (about a 3-log reduction)). The virus was non-detectable on the inner layer of surgical masks at 7 days.

For other surfaces, the length of time it took for virus to become undetectable was:

- Paper, tissue paper: 3h
- Wood, cloth: 2d
- Glass, banknote: 4d
- Stainless steel, plastic, inner layer surgical mask: 7d

16. What are the best practice recommendations to extend the use of masks?

A: Extended use involves using your PPE (such as a mask) for a longer time than normally recommended by best practices. When a mask becomes soiled/contaminated or you must remove it (e.g. to eat) then the mask is to be disposed of. Re-use involves the use of a mask over an extended period of time, removing and storing the mask as defined by your facility policy, and then re-applying the same mask for

use again. Re-use creates a higher risk than extended use, as you are re-applying potentially contaminated PPE.

Given the current circumstance of PPE shortages, we must try to conserve our PPE. Some ways to do this include:

- Reaching out to the MOHLTC and the RNAO regional representative to report PPE supply shortages and request further supplies:
  • Ministry's Health Care Provider Hotline at 1-866-212-2272
  • EOCLogistics.MOH@ontario.ca
- Considering the use of expired masks and respirators (the straps are intact, there are no visible signs of damage, N95 respirators can be fit-tested)
- Organizing care to reduce the number of times you enter the room of a patient with COVID-19
- Maintaining social distancing among staff members

At this time, facilities are being asked to save their used masks and N95 respirators. There are some potentially effective PPE reprocessing techniques that may be recommended for use in the future.
If you are critically low in supplies and are considering extended use of masks, please ensure you follow proper donning and doffing protocols, hand hygiene protocols, and dispose of contaminated, soiled or damp masks and N95 respirators as per facility/Ministry of Health policy and direction. For re-use of PPE, such as face shields and goggles, please follow the manufacturer's recommendations for low-level disinfection, store the PPE in a clean compartment, such as a paper bag marked with the staff members' name, and ensure the PPE is not shared between staff.

For eye protection and face shields, if no specific disinfection instructions are provided by the manufacturer, 70% alcohol (with a contact time of 10 minutes) may be sufficient for disinfection, although this should be verified with the manufacturer as the disinfectant may impact the integrity of the eyewear/face shield.

Please see the PHO document on What We Know So Far about Re-use of PPE.

17. Are we allowed to accept food donations and items brought by families into the facility?

A: As per the PHO document: COVID-19 – What We Know So Far About… Routes of Transmission, there is no specific evidence documenting transmission through fomites (objects). However, the virus has been detected on surfaces in the patient environment and this is a likely potential source of transmission based on experience with other coronaviruses. However, the probability of it being on food or flowers is low.

Facility policy and procedure permitting, residents may receive food and personal items from family members. Where possible, containers can be wiped down with disinfectant. Donated food items are not permitted. Proper hand hygiene is to be performed before and after handling items provided from home.

Please keep in mind that there is to be no food or drink in clinical areas, it should be kept in a staff lounge.

18. Is the PHU or the facility responsible for approving the return-to-work of staff members who have COVID-19?

The PHU will identify when the health care worker can come out of self-isolation. The occupational health representative (or designate) will confirm if the staff member can return to work.

19. What PPE is required for staff members working in Assessment centres?

- Healthcare workers (HCW) who will be in direct contact with patients or within 2m of assessment centre attendees (e.g., HCW conducting screening/assessment and specimen collection (if applicable) are to wear a surgical/procedure mask, gloves, eye protection and a gown. Ideally PPE is to be discarded after each use. If PPE is in short supply, you may be able to use PPE for an extended time or reuse PPE in a safe manner.
- Non-healthcare staff (e.g., security, reception, greeters, cleaners etc.) who are within the assessment centre but are not involved in client screening/assessment and who may be within 2m of attendees are to wear a surgical mask. This may be worn for an extended period
- Assessment centre staff who will not be within 2m of attendees do not require PPE.

20. How do we identify a hospital-acquired COVID-19 infection?

The local PHU can help make decisions about what is considered a hospital-acquired infection. It depends on many factors, such as risk factors and symptom onset.

21. Is CPR considered an aerosol-generating medical procedure (AGMP)?

Performing the all-important chest compression is not an AGMP. The next steps which involves intubation and manual ventilation are considered to be AGMPs. What this means is that chest compressions may begin right away and the person who will perform the manual ventilation and intubation would put on their N95 respirator and wear eye protection. Consider having a respirator (the type most commonly worn) and eye protection as part of the intubation tray set up.

Please see PHO's FREQUENTLY ASKED QUESTIONS COVID-19: Aerosol Generating Medical Procedures for more information on AGMPs.