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Directive 03-10
June 16, 2003

**DIRECTIVE TO ACUTE CARE FACILITIES IN THE GREATER
TORONTO AREA (TORONTO, YORK, AND DURHAM REGIONS)***

**Note: Peel, Halton and Simcoe County are excluded at this time*

This Directive **replaces** the following Directives issued to Acute Care Facilities:

- *DIRECTIVE TO ACUTE CARE FACILITIES IN THE GREATER TORONTO AREA (TORONTO, YORK AND DURHAM REGIONS), Directive 03-09, May 31, 2003*

This Directive **supplements** but does not replace the following Directives. The Directions issued in this document are to be considered to be an enhancement of previous Directions as appropriate. The following relevant Directives remain in place and should be referenced in conjunction with Directive 03-10:

- a. DIRECTIVES TO ALL ACUTE CARE FACILITIES (03-04)(R).*
- b. DIRECTIVES TO ALL ONTARIO ACUTE CARE HOSPITALS FOR HIGH-RISK PROCEDURES (03-11)*
- c. UPDATED PROVINCIAL INTER-FACILITY PATIENT TRANSFER DIRECTIVE, May 12, 2003*
- d. DIRECTIVES TO ALL ONTARIO ACUTE CARE HOSPITALS CONCERNING DISCHARGE OF NON-SARS PATIENTS (03-02)(R)*
- e. DIRECTIVES TO ALL ONTARIO ACUTE CARE HOSPITALS CONCERNING DISCHARGE OF SARS PATIENTS (03-03)*

In order to contain the spread of SARS (Severe Acute Respiratory Syndrome), the Ontario Ministry of Health and Long-Term Care directs all acute care facilities in the Toronto, York and Durham Regions to take the following action immediately:

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1. As required by Directive 03-08, the volume of patient activity in each hospital must be reduced to allow the hospital to continue to respond to its Emergency Department needs. It is anticipated that this priority will require curtailment of booked procedures and non-urgent surgeries. (*The Hospital for Sick Children, University Health Network and Sunnybrook and Women's College Health Science Centre are exempt from this provision*).
2. Hospitals must be prepared to implement Code Orange as directed.
3. For SARS Category 2 and 3 facilities, precautions and restrictions may be applied to affected areas only or to the entire facility, in consultation with the local Medical Officer of Health, and with concurrence of the Ministry of Health and Long-Term Care through the SARS Operations Centre.
4. Hospitals must restrict access to each hospital site. Ideally, access will be restricted to one staff entrance AND one public entrance for each building.
5. Hospitals are to post appropriate signage as required by Directive 03-04(R). The signage must be updated **daily** to reflect the most recent affected areas and facilities. This information can be obtained by referring to the www.health.gov.on.ca/login site
6. Visitors will be limited.
7. Hospitals must implement full surveillance using the SARS Screening Tool (see attached Screening tool) at all entrances for all persons entering the facility.
 - a) The hospital chief of staff or her/his designate in consultation with infection control may make an exception for a health care worker who fails the screen if the exclusion might result in severe health consequences for a patient and it is clinically appropriate to do so. Such exceptions must be documented and retained on the screening tool and on the affected patient/patients' chart.
 - b) SARS precautions (gown, gloves, N95 mask or equivalent, protective eye-wear) are to be used by the screener in Emergency Departments. Screeners at other entrances require N95 mask or equivalent, protective eyewear, and must practice good hand hygiene.
 - c) Taking temperature as part of the screening process is required if the person is experiencing any of the following symptoms:
 - Unexplained myalgia (muscle aches) **OR**
 - Unexplained malaise (severe tiredness or unwell) **OR**
 - Severe headache (worse than usual) **OR**
 - Cough (onset within 7 days) **OR**
 - Shortness of Breath (worse than what is normal for the person) **OR**
 - Feeling feverish, had shakes or chills in the last 24 hours **OR**
 - If the person is staff on working quarantine

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People being screened are required to self-identify if they feel feverish.

- d) Health care workers, including physicians, must sign the screening forms (electronic signatures/confirmation is acceptable as long as accountability is clear). Signatures for visitors and patients are to be requested but are not mandatory.
8. For all patients on admission to a health care facility, the names of all other facilities the patient has been admitted to or treated at in the 10 days prior to admission will be documented. This up-to-date list of patients and hospitals will be available to Public Health if it becomes necessary to track patient contacts.
9. Health care providers in the Emergency Department areas will wear SARS precautions of N95 mask or equivalent, gown, gloves, and protective eyewear while providing patient care in those areas. Between patients, gloves must be changed and the wearer must perform hand hygiene. If patients are thought to have SARS, then additional SARS precautions apply (negative pressure rooms (as available) etc. as outlined in previously circulated directives).
10. Health care providers in Critical Care areas (Intensive Care Units, Coronary Care Units, Operating Rooms) will wear SARS precautions of N95 mask or equivalent, gown, gloves, and protective eyewear while providing patient care in those areas. All personal protective equipment must be changed between patients. If patients are thought to have SARS, then additional SARS precautions apply (negative pressure rooms (as available) etc. as outlined in previously circulated directives).
11. **Health care workers must maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symptoms.** Fever alone must be considered as a sign of potential infection and should be considered even in the absence of other signs or an epidemiological link. Therefore, any patient developing the following symptoms or signs on or after admission – fever, unexplained cough, unexplained hypoxia, shortness of breath or difficulty breathing – must be evaluated immediately. If SARS cannot be ruled out for those with fever and a respiratory symptom as listed above, then treat as follows:
 - a) Transfer to a single room if available. If a single room is not available, cohort similar case presentations (e.g., congestive heart failure cases with other patients with congestive heart failure) and maintain at least one metre spatial separation between beds. If there is more than one patient in a room, the curtains must remain closed between beds to minimize droplet transmission.
 - b) Patient activity must be restricted i.e. patients remain in their room with the door closed until SARS is ruled out.
 - c) All visitors and health care workers must take full SARS precautions (gown, gloves, N95 mask or equivalent, and protective eyewear). Where possible, diagnostic and therapeutic procedures (e.g., imaging, haemodialysis) must be done in the patient's room.

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- d) Patients may be out of the room for essential procedures only and must wear a surgical mask during transport.
 - e) The room must be cleaned according to hospital infection control procedures.
12. All hospitals must institute active surveillance for infectious respiratory illnesses as outlined in the appended document Active SARS Surveillance Program.
 13. All hospitals are required to provide access to 24-hour infection control coverage.
 14. All hospitals must be prepared to open or maintain SARS isolation units as necessary.

Original signed by

Original signed by

Dr. James G. Young
Commissioner of Public Security

Dr. Colin D’Cunha
Commissioner of Public Health
and Chief Medical Officer of Health

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ACTIVE SARS SURVEILLANCE PROGRAM

For Acute Care Facilities for Toronto, York and Durham Regions

Background:

Active surveillance is an important epidemiological tool that serves a variety of purposes, both during active outbreak situations, and during times when specific outbreaks are not declared.

The ability to identify cases early in an outbreak, or in anticipation of an outbreak, offers enhanced protection to patients, staff visitors and the community at large. It also identifies the need for appropriate infection control precautions and prevents transmission of disease.

The presence of an Active Surveillance Program in acute care hospitals is important for the early identification of “clusters” of cases requiring investigation. Regular attention by clinical nursing and hospital staff to the combination of certain symptoms (e.g., “fever and respiratory symptoms”) in a systematic fashion across the hospital environment also provides continuous opportunities for staff education on both infection control practices and other SARS-related information. An Active Surveillance Program minimizes the possibility that SARS cases will be missed.

Further, an appropriately resourced Active Surveillance Program will build and maintain public confidence in the public health and hospital care systems, both during periods of transition and over time.

Ultimately, an efficient system will significantly reduce costs to both human and other resources.

An Active Surveillance Program is not meant to replace Infection Prevention and Control practices already in place in acute care hospitals, but rather to supplement them.

Program Elements:

The Active SARS Surveillance Program described below is designed to apply to all in-patient units, with the exception of Critical Care Units. Another method of case finding will be developed for Critical Care Units.

To have an Active Surveillance Program in place, the following procedures are required:

1. On admission, in addition to questions currently on the SARS Screening Tool, all patients must be asked if they are a health care worker, or if anyone in their household has pneumonia.
2. Unit staff are responsible to make notations on the surveillance sheet (see sample Daily SARS Surveillance Tool, [Appendix 1](#)) for each of their assigned patients who has an unexplained fever, cough, hypoxia and/or shortness of breath. Copies of the surveillance tool are to be maintained on the in-patient unit.
3. An assigned surveyor (not required to be an Infection Control Practitioner) is responsible for going to all in-patient units each day to review the patient lists and interview staff

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and/or review patient charts as necessary. (This person will work under the direction of the Infection Control Practitioner at the site).

4. The surveyor and Infection Control Practitioner will review all information gathered by this surveillance to enable Infection Control staff to quickly determine if there are gaps in the identification of at-risk patients and their appropriate isolation. (See sample "SARS Surveillance Report" line list, [Appendix 2](#).)
5. The ID physician/Infection Control Committee Chair or medical designate is consulted when additional medical diagnosis and/or evaluation of identified cases is required.
6. Regular analysis of the data is performed by the Infection Control Practitioner in consultation with an ID/Infection Control Physician or, in those sites without an Infectious Diseases physician, by the physician designated by the hospital to review the same.
7. Infection Control is required to immediately notify Public Health of clusters of symptoms or any patients who meet the SARS PUI, suspect or probable case definitions.

Resources:

Hospitals should allocate appropriate additional resources to ensure a successful program.

It is recommended that the following components be added to current Infection Control/Infectious Disease staffing or resource levels:

- 1 additional FTE/500 beds dedicated to Active Surveillance.
- 5-10 hours per week of physician resources for assistance with medical evaluations and surveillance epidemiological review.
- Resources for data management. This should include, but is not limited to, a computer, appropriate programs and personnel for data entry.

Evaluation:

An audit of the surveillance is to be performed by the Infection Control program at regular intervals to ensure all required elements have been implemented as required.

A review and assessment of the Active Surveillance program is required one month after the resolution of the outbreak to ensure that its effectiveness can be maintained and the appropriate resources are in place for the longer term. The facility will establish a process for regular evaluation of the effectiveness of the Active Surveillance program and make changes to the program as appropriate.

Appendix 1

Date: _____

Form completed by: _____

Patient Unit: _____

SAMPLE

Daily SARS Surveillance Tool

Any new onset of symptoms of fever, cough and shortness of breath in patients must be reported to the attending physician and Infection Control immediately.

All patients are to be reviewed daily by unit team leader/charge nurse for any new onset of these symptoms. Names are to be documented below and faxed to Infection Control at extension _____ by 1100 hours daily.

Name	Date of onset	Room #	ID#	Fever >38°C	Cough	SOB	Hypoxia	Currently on Respiratory Precautions?	Action

Appendix 2

SAMPLE

**INFECTION PREVENTION AND CONTROL PROGRAM
SARS SURVEILLANCE REPORT**

Date: _____

Form completed by: _____

Patient Unit: _____

Name of Patient	Date of Admission/Room #	Date of Onset of Symptoms	Clinical Findings CXR Findings F=fever; My=myalgia SOB; H=headache M=malaise; C=cough; WBC	Symptomatic Relatives e.g. pneumonia in relatives		Has been to an affected hospital /site in the past 10 days		The patient is a health care worker		Has recently traveled to an affected area		New potential SARS Category	Action
				Yes	No	Yes	No	Yes	No	Yes	No		

Directions for Use:

1. If persons have symptoms but answer “no” to epidemiological links, keep on droplet/contact precautions (N95 mask, eye protection, gown, gloves) X 72 hours and observe for any deterioration or improvement.
2. If persons have symptoms and any confirmed epidemiological link, notify Public Health, Infection Control Officer and maintain SARS precautions
3. If a cluster of symptomatic cases identified with or without geo/epidemiological link, notify Public Health