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Directive P03-01
June 17, 2003

DIRECTIVE FOR PAEDIATRIC FACILITIES IN THE GREATER TORONTO AREA (TORONTO, YORK, AND DURHAM REGIONS)*

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

This Directive is a modification of the Directive to Acute Care Facilities in the Greater Toronto Area (Toronto, York, and Durham Regions) (Directive 03-10, June 16, 2003) and addresses the care of paediatric patients in a dedicated paediatric hospital or on a dedicated paediatric unit of an acute care facility. If paediatric patients are seen in settings along with adults (e.g., combined emergency departments, maternal-neonatal units), the adult acute care directives apply.

It is recognized that in general SARS (Severe Acute Respiratory Syndrome) is a relatively mild infection in children. Furthermore our experience to date shows that children with SARS have primarily been children of adults with the disease, or more rarely, children from countries affected by SARS. Taking these points into account, the following actions must be implemented:

1. Hospitals must be prepared to implement Code Orange as directed.
2. If the institution or unit is designated SARS Category 2 or 3, additional precautions and restrictions may be applied to affected areas only or to the entire facility, based on consultation with the local Medical Officer of Health.
3. Hospitals must restrict access to each hospital site. Ideally, access should be restricted to one staff entrance AND one public entrance for each building.
4. Hospitals are to post appropriate signage as required by Directives to all Ontario Acute Care Facilities - Directive 03-04(R), May 13, 2003. 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 password sarsrep.

5. Visitors should be limited.
6. Hospitals must implement full surveillance using the SARS 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.
 - 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

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

- d) Health care workers, including physicians, must sign the screening forms. Signatures for visitors and patients are to be requested but are not mandatory.
7. For all patients on admission to a health care facility, document the names of all other hospitals the patient has been admitted to or treated at in the 10 days prior to admission. Maintain an up-to-date list of patients and hospitals for reporting to Public Health if this becomes necessary.
8. **Paediatric modification:** Routine practices as defined by Health Canada should be used for all patient care (including intensive care units and emergency departments) which includes hand hygiene before and after each patient contact. In addition, gowns, gloves, N95 masks or equivalent and protective eye-wear must be worn for anticipated exposure to blood, body fluids, secretions, excretions, non-intact skin and mucous membranes.
9. SARS precautions consisting of N95 mask or equivalent, gown, gloves, and protective eyewear should be used while providing patient care to patients with

- suspected infectious respiratory illness. All personal protective equipment should be changed between patients and hand hygiene must be performed.
10. If patients are thought to have SARS, additional SARS precautions apply, including the use of negative pressure rooms, and a face shield along with goggles. For SARS units health care workers should wear a head cover and a second pair of gloves in addition to the protective equipment described above. (see SARS unit directive)
 11. Health care providers involved in aerosol generating procedures, and those within a two metre radius of the patient undergoing the procedure will wear SARS precautions including N95 mask or equivalent, gown, gloves, and protective eye-wear. (see Directive to all Ontario Acute Care Hospitals for High-Risk Procedures – Directive 03-11, June 16). All personal protective equipment must be changed between patients.
 12. **Health care workers should maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symptoms.** Fever without another cause must be considered as a sign of potential infection and should prompt further enquiry into possible epidemiological links with persons with SARS. If the patient has unexplained fever and respiratory symptoms and an epidemiological link then treat as follows:
 - a) Transfer to a single room if available. If a single room is not available, cohort 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 should be restricted i.e. patients should remain in their room with the door closed until SARS is ruled out
 - c) All visitors and health care workers 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
 - d) Patients should be out of the room for essential procedures only and wear a surgical mask during transport.
 11. All hospitals must institute active surveillance for infectious respiratory illnesses as outlined in the appended document Active SARS Surveillance Program.
 12. All hospitals are required to provide access to 24-hour infection control coverage.
 13. All hospitals must be prepared to open or maintain SARS isolation units as necessary.

Dr. James G. Young
Commissioner of
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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 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