Acute Care Guidelines for Patient Admission/Discharge/Transfer in Unit/Facility with a Confirmed COVID-19 Outbreak or on Watch

These guidelines are intended to provide points of consideration for the Outbreak Management Team in decision-making when a COVID-19 outbreak is declared (as defined in the Acute Care COVID-19 Outbreak Control, Prevention and Management Guidelines). They are not prescriptive, and, require the Outbreak Management Team to consider the potential implications of all decisions to the facility and the geographic area.

Admissions to Outbreak Unit/Facility

Where possible and where access to service is available elsewhere within the geographic area, avoid admitting to empty beds in a unit that is on outbreak to minimize infection risk to that patient (this would also apply in the event of a facility-wide outbreak).

Admissions can still continue to other units not on outbreak at a facility. If there is a facility-wide outbreak, decisions must weigh the risk of admitting patients versus the risk of not having a service available.

If it is necessary to admit to these beds because of capacity issues at the facility, or because there are no other acute care facilities in the geographic area, or for specialized clinical services, *consider* the following factors to mitigate/decrease risk to the patient:

Status of Outbreak

- Is the outbreak under control (i.e. stable as defined by the Outbreak Management Team and where transmission chains are understood by the Team)?
    - If new cases are still occurring in patients and/or healthcare workers (HCWs), despite implementation of control measures, consider not admitting, particularly if those cases are occurring outside of the suspected transmission chain (i.e. when the outbreak does not seem to be controlled).

Patient Factors

Consider **not** admitting patients with the following:

- Increased risk of severe COVID-19 illness – those over 60 years of age, persons with existing chronic medical conditions (e.g. cardiovascular and liver disorders, diabetes, other respiratory diseases) or immune compromising conditions. See the clinically immunocompromised list in IPC Considerations for Immunocompromised Patients.
- A history of wandering, unless there are no other admission options available; then adapt Management Strategies for the Wandering COVID-19 Patient in Acute Care to manage/reduce risk.
- Other infectious illnesses that could be communicable to others e.g. GI, respiratory (other than COVID-19). If admission must proceed, consult with Infection Prevention and Control (IPC) for additional control measures required.

- Conditions requiring extensive care provision, unless staffing is adequate to manage all patient care needs.

Unit Factors for Consideration

- Do not admit new patients to multi-bed rooms (2 or more beds) **where there are current, active case(s) in the room**. A decision to admit in this circumstance must be made by Site Leadership in consultation with IPC.
- Minimize filling ward rooms (3-4 bed wards) with more than 2 patients where possible.
- Cohort existing COVID-19 cases to create space for non-affected patients. Cohorting decisions should be made in consultation with IPC. Refer to existing documents on cohorting of patients:
  - IPC Cohorting Recommendations for COVID-19 in Acute Care
  - Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities
  - IPC CVID-19 Additional Precautions without Walls in Shared Patient Care Space
- Generally do not admit patients to overcapacity spaces. Consult IPC if necessary.

HCW Factors

- If possible, consider cohorting HCWs to caring only for either COVID-19 infected patients or non-COVID-19 patients. If not possible, provide care to non-COVID-19 patients first, followed by COVID-19 infected patients.
- Ensure those HCWs providing care to COVID-19 infected patients are well trained in donning and doffing PPE and with effective hand hygiene. These measures will protect them and their patients while caring for both COVID-19 infected patients and patients without COVID-19.

Communication

Communication to the patient and family upon admission to an outbreak unit should be done by the most responsible healthcare provider (e.g. admitting physician), prior to admission if bed assignment known. Communication should focus on measures that are/will be in place to prevent exposure. See *Acute Care Communications* for standardized templates for this and other communications during outbreaks, which should also be included in the Zone's Acute Care Outbreak Toolkit. The Outbreak Management Team may modify these according to the specifics of the outbreak situation and determine who will be sending out the communication. Some examples include:

- Admission Letter (FMC)
- Discharge Letter (FMC)

Testing of Inpatients on Outbreak Unit

Testing of inpatients is voluntary, and consent must be obtained from the patient or their guardian/co-decision maker/agent, whether they are symptomatic or asymptomatic.

Approval for rapid testing in an outbreak situation is not required. All inpatients in sites with access to rapid testing will automatically be tested on the rapid testing platform.

If a patient is asymptomatic and has not been tested for COVID-19, test before discharge or transfer, ideally 2 days prior, to inform isolation requirements and medical advice as appropriate. A negative result applies only at the point the specimen was taken.

Serial point prevalence testing of patients on acute care units on outbreak is currently being recommended, so most patients will have had at least one testing opportunity before discharge. Decisions about testing intervals are to be made by the Outbreak Management Team, based on the outbreak characteristics.

Discharges from Outbreak Unit/Facility

To Home in Community

A positive COVID-19 test result should not delay discharge home if the patient is medically stable (see points below for discharging patients testing positive) and able to isolate.

If the patient is COVID-19-positive and still infectious, but medically ready for discharge, consider the following before discharge:

- Is patient likely to be compliant with isolation at home? If unwilling or unable to safely isolate at home, consider discharging to alternative living arrangement or secure or assisted self-isolation facility until isolation is lifted by Public Health. Consult with ZEOC/ZEL and/or Transition Services regarding access to such isolation facilities, if they exist, in the zone.
- For home isolation:
    - Is there an appropriate healthy person at home to provide care to the patient if needed?
        - If not, explore other options for care provision at home.
    - Are any household contacts essential services workers (e.g. healthcare worker)?
        - Close contacts of confirmed and probable cases of COVID-19 are required by Alberta CMOH Order to quarantine for 14 days from the last date of exposure to the case [see Public health disease management guidelines - COVID-19].
        - If so, the essential worker could seek an alternate living arrangement.
    - Is the home environment suitable for isolation? Separate bedroom and separate bathroom are preferred but other arrangements are possible with adequate separation and frequent cleaning and disinfection. Review How to Care for a COVID-19 Patient at Home with patient.
    - Are there household members present at increased risk of severe COVID-19 infection (e.g. people over 60 years of age, and those with chronic medical

conditions such as high blood pressure, heart disease, lung disease, cancer or diabetes)?
        - Explore options to keep these individuals from having close contact with the patient.
    - Ensure medical management in the community is in place (e.g. Home Care, PCN, Primary Care Provider etc.)
- If patient is COVID-19-negative and not otherwise required to isolate or quarantine (i.e. not symptomatic, not a close contact of a case or a returned traveller), no isolation or quarantine is required at home. The patient should continue to monitor for COVID-19 symptoms, and if they occur, they should isolate and access testing through the AHS online assessment or by calling 811.

If testing is not done, or result is not available before discharge home, recommend that the patient be placed on quarantine for 14 days as a precaution.

- Encourage patients to register for MyAlberta Digital ID to help them in reviewing their own test results on MyHealth Records when applicable.
- Advise that information for patients tested for COVID-19 is available at ahs.ca/results.
- Public Health follows up on COVID-19-positive results, automatically.
- No Public Health follow up is done for negative results.

Refer to Patient Discharge from Hospital resources on Insite (see *References*).

To Shelters, First Nations (FN) Communities, Metis Settlements, Correctional Facilities

Generally avoid discharge of patients from acute care outbreak units/facilities to emergency shelters, FN communities or Metis settlements, or correctional facilities unless the patient is known to be non-infectious (e.g. tested positive and has been released from isolation).

If **unwilling or unable** to safely isolate or quarantine after discharge, consider discharging to alternative living arrangement or secure or assisted self-isolation facility until isolation is lifted by Public Health. Consult with ZEOC/ZEL and/or Transition Services regarding access to such isolation facilities, if they exist, in the zone.

If patient tests negative and is asymptomatic, consider discharge only when communications with the receiving site/community has been established and the discharge is accepted.

See Appendix H-2 of the COVID-19 Safe Discharge Checklist Appendices for communication to MOHs of First Nations Inuit Health Branch.

Transfers from Outbreak Unit/Facility

If testing is not done, or result is not available before transfer, recommend that the patient be placed on quarantine for 14 days at the receiving unit/facility as a precaution. This quarantine period is required for new admissions/transfers to continuing care facilities and other congregate living settings as this would place them in a higher risk category.

To Other Acute Care Facilities

Inter-facility: Generally avoid transfer of any patient on an outbreak unit to other acute care facilities, unless medically necessary as determined by the clinical care team.

- If medically necessary, consult with IPC and follow recommendations. Notify receiving unit/facility in advance.

Intra-facility: Generally avoid transfer of any patient on an outbreak unit to other units, unless medically necessary, as determined by the clinical care team.

- If medically necessary, consult with IPC and follow recommendations. Notify receiving unit in advance.
- Transfers of COVID-19-positive patients to designated COVID-19 units (intra-facility), if available and open, may proceed with approval by the Outbreak Management Team and with appropriate IPC measures in place.

To Continuing Care Facilities or Other Congregate Living Settings

Generally avoid transfer of patients from acute care outbreak units/facilities to continuing care facilities, if at all possible. If necessary because of capacity issues, in consultation with MOH/IPC and following zone processes, consider the following patient, unit/facility and staffing factors:

Patient is COVID-19-positive: Avoid transferring COVID-19 positive patients who are still infectious if possible. If transfer is to proceed, consider the following:

- Assessment of infectiousness should be made by IPC/IPC Medical, based on status of symptoms (repeat COVID-19 testing is not advised).
- Complete *Risk Assessment Worksheet* with receiving facility, and involve zone MOH/designate as appropriate. The MOH has responsibility for the final decision.
- Patient/resident must remain on isolation at receiving facility, with contact/droplet precautions in place to complete mandatory isolation requirements (i.e. 14 days from symptom onset or symptoms resolve, whichever is longer) as per CMOH Order 32-2020.
- If receiving site has a COVID-19 outbreak itself, transfer could proceed if staffing level at receiving site is adequate and outbreak status is stable as defined by Outbreak Management Team (no new resident cases in several days).

Patient is asymptomatic: Ideally, test patient within 2 days of transfer (and wait for results) before transferring.

- If negative, can proceed with transfer using *Risk Assessment Worksheet* and process, with required 14-day quarantine period in place at continuing care facility. See CMOH Order 32-2020 for specific quarantine requirements.
- If positive, see above.

If receiving site has a COVID-19 outbreak, according to CMOH Order 32-2020:

- The operator must stop admissions into the site, unless at the explicit direction of the AHS Zone Medical Officer of Health.
- Decisions by the MOH shall be made on a case-by-case basis while using consistent decision-making methods.
- Considerations may include: number of people affected, type of symptoms, location of infected residents within the facility, characteristics of the population, number of shared staff between units, acute care capacity, community cases etc.
- Complete *Risk Assessment Worksheet* and involve MOH/designate as appropriate. Other considerations include extent of outbreak (# of resident/HCW cases, number of units affected), status of outbreak (any new resident cases?) and staffing level.

If receiving site is under investigation for COVID-19 due to resident(s) only having symptoms (not staff), the operator should consult with AHS Zone Medical Officer of Health (or designate) before accepting new admissions into the site, according to CMOH Order 32-2020.

- Having isolated and/or quarantined staff member(s) only (i.e. not residents) should not restrict admissions to the site. This is because any staff with COVID-19 symptoms or who has had exposure to COVID-19 should no longer be working at the site until their isolation/quarantine period is complete.

Unit/Facility is on Watch (Pre-Outbreak)

Admissions to Unit on Watch

Restrictions to admissions to a unit or facility **on watch** are generally not recommended. The Outbreak Management Team may determine to implement admission restrictions that could encompass some, or all of those for consideration for a unit/facility on outbreak, depending on the particular circumstances. For example:

- If there are a significant number of close contacts, especially symptomatic close contacts, admissions may be held until the investigation is complete.
- Depending on the circumstances of a specific unit on watch, IPC consultation may be required for new admissions or transfers into the unit.

Generally do not admit to overcapacity spaces. Consult IPC if necessary.

Discharges to the Community

Discharges to home in the community, shelters, FN communities, Metis settlements or correctional facilities can proceed unless patient is COVID-19-positive and infectious. See considerations for *units on outbreak*.

Transfers from Unit/Facility on Watch

To other acute care units/facilities:

- Generally acceptable to transfer a patient in a unit on watch to other units/acute care facilities, unless patient is COVID-19-positive (and infectious) or symptomatic, or is a close contact/has been potentially exposed to the individual who has prompted the on watch status.
- Consult with IPC for specific directions regarding any additional precautions that may be required on transfer. Advise receiving unit/facility of patient details.
- Transfers of COVID-19-positive patients to designated COVID-19 units (intra-facility), if available and open, may proceed with approval by the Outbreak Management Team and with appropriate IPC measures in place.

To continuing care facilities or congregate living settings:

- Generally acceptable to transfer a patient in a unit on watch to continuing care facilities, with discussion by the Outbreak Management Team, unless patient is COVID-19-positive (and infectious) or symptomatic, or is a close contact/has been potentially exposed to the individual who has prompted the on watch status.

- **If receiving site has a COVID-19 outbreak, according to CMOH Order 32-2020**:
  - The operator must stop admissions into the site, unless at the explicit direction of the AHS Zone Medical Officer of Health.
  - Decisions by the MOH shall be made on a case-by-case basis while using consistent decision-making methods.
  - Considerations may include: Number of people affected, type of symptoms, location of infected residents within the facility, characteristics of the population, number of shared staff between units, acute care capacity, community cases, etc.
  - Complete Risk Assessment Worksheet and involve MOH/designate as appropriate. Considerations include extent of outbreak (# of resident/HCW cases, number of units affected), status of outbreak (new resident cases?), staffing level.

- **If receiving site is under investigation for COVID-19** due to resident(s) only having symptoms (not staff), the operator should consult with AHS Zone Medical Officer of Health (or designate) before accepting new admissions into the site, according to CMOH Order 32-2020.
  - Having isolated and/or quarantined staff member(s) only (i.e. not residents) should not restrict admissions to the site. This is because any staff with COVID-19 symptoms or who has had exposure to COVID-19 should no longer be working at the site until their isolation/quarantine period is complete.

References

- MOH Guidelines for Transfers, Discharges and Admissions During COVID-19 Pandemic
- CMOH Order 32-2020
- AH Public Health Disease Management Guidelines: Coronavirus - COVID-19

Discharge Process (on Insite):

- COVID-19 Safe Discharge Checklist Appendices
- COVID-19 Safe Discharge Home Checklist
- My Discharge Checklist
- Staff Script for the COVID-19: My Discharge Checklist
- Provincial Pandemic Flowsheet