Acute Care Guidelines for Admission to, or Discharge/Transfer from, a unit/facility with a confirmed COVID-19 outbreak

These guidelines are intended to provide points of consideration for the Outbreak Management Team (OMT) 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 OMT to consider the potential implications of all decisions to the facility and the geographic area.

Outbreak

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.

1. Status of outbreak
   - Is the outbreak under control (i.e. stable as defined by the OMT and where transmission chains are understood by the Team)?
     - if new cases are still occurring in patients and/or health care workers (HCW) 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).
   - It does not matter if this is a VOC or non-VOC outbreak.

2. Patient factors
   If admissions to the outbreak unit must occur, consider NOT admitting patients to the outbreak unit in the following situations:
   - Patients with conditions that present an increased risk to themselves or others if they become infected, including but not limited to:
     - an 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 - then adapt Management Strategies for the Wandering COVID-19 Patient in Acute Care to manage/reduce risk.
     - other concerns which may result in decreased compliance with preventive measures.
• 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.
  • those who are not adequately immunized.

• Patients with conditions requiring extensive care provision unless staffing is adequate to manage all patient care needs.

The OMT can consider the following:
• Admitting patients with COVID-19 currently who require hospitalization if VOC screening results are known (following cohorting guidelines).
• Admitting patients who are resolved (recovered) cases
• Converting the OB unit into a COVID-designated unit.

3. Unit factors
• Do not admit new non-COVID or suspected COVID patients to multi-bed rooms (2 or more beds) where there are current, active COVID case(s) in the room. A decision to admit in this circumstance must be made by Site Leadership in consultation with IPC.
• Cohort existing and newly admitted COVID-19 cases to create space for non-affected patients. Follow IPC cohorting guidelines, in consultation with IPC:
  o IPC Cohorting Recommendations for COVID-19 in Acute Care
  o Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities
  o IPC COVID-19 Additional Precautions without Walls in Shared Patient Care Space
  o Patient Cohorting for COVID-19 (Including Variant Strains)
• Do not admit patients to overcapacity spaces. Consult IPC if necessary.
• Consider unit infrastructure and ability to ensure safe care for the patient and others e.g. need to consider size of rooms, unit configuration, availability of handwashing/hand cleaning facilities, extent of clutter, ability to isolate the unit if required, etc.

4. HCW factors
• If possible, consider cohorting HCW 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 HCW providing care to COVID-19 infected patients are well-trained in donning and doffing PPE and with effective hand hygiene; these measures will protect these HCWs and their patients while caring for both COVID-19 infected patients and patients without COVID-19.
• Immunization status of HCWs is not a factor in staffing decisions for the outbreak unit.

Communication to patient/family of admission to outbreak unit should be done by the most responsible healthcare provider (e.g. admitting physician) prior to admission, focusing on measures that are/will be in place to prevent exposure. Use standardized templates for this and other communications during outbreaks, which should also be included in zones’ Acute Care Outbreak toolkits; the OMT may modify these according to the specifics of the outbreak situation and determine who will be sending out the communication. Some examples include:
• Provincial Discharge Letter
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 laboratory-based polymerase chain reaction (PCR) testing in an outbreak situation is not required. All inpatients in sites with access to rapid lab-based testing will automatically be tested on the rapid lab-based testing platform.

If 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 will be made by the OMT, based on the outbreak characteristics.

- According to CMOH Order 23, 2021, testing recommendations for those inpatients being admitted/returning to continuing care facilities are available in the Alberta Health Public Health Disease Management Guidelines – coronavirus COVID-19:
  - Testing is recommended for all new residents admitted to a congregate living facility, e.g., licensed supportive living (including lodges and group homes), long-term care (nursing homes and auxiliary hospital) and hospices, regardless of symptoms upon admission.
  - Residents who return to these settings post-hospitalization for non-COVID-19 illnesses are also recommended to be tested whether they have symptoms or not. [NOTE: A fully immunized* asymptomatic resident does not require testing prior to returning to a congregate living facility, unless MOH or designate/IPC recommend testing.]

* A person is considered fully immunized if it has been more than 14 days since they received two doses of COVID-19 vaccine in a two-dose vaccine series OR more than 14 days since they received one dose of vaccine in a one-dose vaccine series.

To be cautious, Alberta Health recommends that individuals who are immunocompromised and fully-immunized follow the protocol for partially-immunized individuals. If an immunocompromised person is partially immunized, it is recommended to follow the protocol for those who have not been immunized.

Discharges from Outbreak Unit/Facility

1. 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 safely.
   - **If patient is COVID-19 positive** and still infectious (or symptomatic and has refused testing) but is 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 or commercial isolation hotel (if available) 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.
- Provincial Commercial Isolation referrals for government approved hotels received directly from EDs and inpatient units are prioritized as “urgent” to support site capacity and patient flow
  - For home isolation:
    - Immunization status of home caregiver and other household members must be considered in discharge planning.
    - 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. health care worker)?
      - Close contacts of confirmed and probable cases of COVID-19 shall by CMOH Order be in quarantine for 14 days from the last date of exposure to the case. [see Public health disease management guidelines - COVID-19].
      - If yes, the essential services worker could seek an alternate living arrangement. If fully immunized the worker wouldn’t be deemed a close contact and would not require quarantine if asymptomatic.
    - Is 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, but they should 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 patient is fully immunized**, no quarantine is required unless recommended by MOH/designate or IPC.
- **If patient is not adequately immunized**, quarantine requirements will be as per CMOH Order 26-2021.
- **If testing is not done**, or result is not available before discharge home, and patient is not symptomatic, 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 https://www.albertahealthservices.ca/topics/Page17034.aspx.
- Positive results are followed up by Public Health automatically.
- Negative results – no Public Health follow-up is done.
2. **To shelters, First Nations (FN) communities, Metis settlements, correctional facilities:**

- Avoid discharge of patients from acute care outbreak units/facilities to emergency shelters, FN communities or Metis settlements, or correctional facilities unless 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 or commercial isolation hotel (if available) 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 have 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.
  - If fully immunized and asymptomatic, quarantine may not be required depending on the setting and MOH or designate/IPC/facility recommendations.

**Transfers from Outbreak Unit/Facility**

If testing is not done, or result is not available before transfer, recommend that the quarantine requirements of CMOH Order 23-2021 (or subsequent replacement Orders) be followed at the receiving unit/facility.

- The MOH, their designate or the IPC team may require different, more stringent quarantine requirements for individuals than those in the Order. These requirements must be clearly communicated to the facility.

1. **To other acute care facilities:**

- **Inter-facility:** 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.
  - Repatriation is not considered a medically necessary reason for transfer.
  - Immunization status of the patient is not a consideration for transfer.

- **Intra-facility:** 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 OMT and with appropriate IPC measures in place.
2. 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 COVID-19 positive:** Avoid transferring COVID-19 positive patients who are still infectious if possible. If transfer is being considered:
     - Assessment of infectiousness and duration of isolation should be made by IPC, based on
       status of symptoms and patient factors. 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 and Droplet
       precautions for 14 days or until symptoms improve AND they are afebrile (have no
       fever) for 24 hours without the use of fever reducing medications, whichever is longer as
       per [CMOH Order 23-2021](#).
     - If receiving site has a COVID-19 outbreak itself, transfer is not permitted unless at the
       explicit direction of the AHS Zone MOH. See [CMOH Order 23-2021](#).
   - **Patient asymptomatic:** ideally, test patient within 2 days of transfer (and wait for results) before
     transferring.
     - If negative, can proceed with transfer using zone Risk Assessment Worksheet and
       process, with recommended quarantine as per CMOH Order 23-2021 (or subsequent
       replacement Orders) to be followed at the receiving unit/facility unless modified by a
       zone MOH/designate.
     - If positive, see above.
   - If patient is not tested, follow the requirements of [CMOH Order 23-2021](#) (or subsequent
     replacement Orders) in relation to quarantine at the receiving unit/facility unless the
     MOH or designate/IPC communicates other requirements because of risk.
   - **If receiving site has a COVID-19 outbreak,** according to [CMOH Order 23-2021](#):
     - 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, and
         immunization coverage at the site, 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 (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 23-2021](#).
     - 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.
On Watch

Admissions to Unit on Watch

- Restrictions to admissions to a unit or facility on watch are not generally 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 on watch unit, 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 home in community, to shelters, to FN communities or Metis settlements, to correctional facilities

Can proceed unless patient 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 OMT, 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.
  - Transfer of asymptomatic fully immunized close contacts may occur unless the MOH or designate/IPC provides other recommendations.
- If receiving site has a COVID-19 outbreak, according to CMOH Order 23-2021:
  - 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, immunization coverage at the site 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 23-2021.
  o 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

- AH Public Health Disease Management Guidelines: Coronavirus - COVID-19

- Discharge Process from AHS Insite
  o COVID-19 Safe Discharge Checklist Appendices
  o COVID-19 Safe Discharge Home Checklist
  o My Discharge Checklist
  o Staff Script for the COVID-19: My Discharge Checklist