

## FREQUENTLY ASKED QUESTIONS

# (ARCHIVED) Frequently Asked Questions for Interim IPAC Measures based on COVID-19 Transmission Risks in Health Care Settings

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### ARCHIVED DOCUMENT

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## Introduction

The [Interim Infection Prevention and Control \(IPAC\) Measures Based on COVID-19 Transmission Risks in Health Care Settings](#)<sup>1</sup> technical brief was developed to provide an overview of the practical implementation of IPAC measures in health care settings during the COVID-19 pandemic in the context of changing epidemiology during the pandemic. The technical brief was written with acute care settings as the primary audience, however, it is acknowledged that these principles may be applied to other settings where healthcare is provided (e.g., long-term care homes [LTCH], congregate living settings [CLS], primary care).

Below are a series of frequently asked questions to assist with the translation/application of the document. Health care settings should adhere to legislative requirements and consult Ministry and local Public Health Unit (PHU) guidance applicable to their organization/setting. As additional evidence emerges these interim recommendations and frequently asked questions will be updated.

## Questions and Answers

**Q1: How are the periods of high risk, transitional and low risk determined and what are the indicators and thresholds for movement between them?**

Level of transmission risk within health care settings is largely dependent on SARS CoV-2 community incidence (e.g., community positivity rate, wastewater surveillance). Indicators such as COVID-19 hospitalizations per 100 000 community population, outbreaks and staff positivity and absenteeism (e.g., awaiting testing or due to high risk exposure) within healthcare settings can be considered a proxy of community incidence. Thresholds for infection rates or other indicators have not been defined for each risk period as there is no evidence to support a specific quantitative threshold/cut off and risk tolerance will differ based on multiple dynamic factors (e.g., local epidemiology, population at risk,

immunization coverage, emergence of immune escape variants, etc.). In addition, there may be differences in the weighting of individual criteria in a quantitative or qualitative population-level risk assessment by region and healthcare setting, depending on their unique circumstances. A risk assessment would also include an understanding of an organization's risk tolerance as it will be dynamic and take into consideration unique characteristics of the organization (e.g., patient population, immunization coverage in patients, staff and visitors, psychological health and safety, human resources and infrastructure).

Risk levels can be determined at the level of an organization, health care setting, region or province. Resources have been provided in the technical brief on where provincial, regional and local public health unit metrics can be found including vaccination rates, outbreaks in health care facilities, hospitalizations, ICU admissions, community incidence including wastewater surveillance data. The local public health unit may be consulted for guidance on regional indicators and risk assessments for community COVID-19 transmission. The transmission risk framework for adjusting IPAC measures presented in this document can be used as a starting point to develop an organizational plan along with relevant setting-specific [Ministry guidance](#).<sup>2</sup>

#### **Resources:**

[COVID-19 Data and Surveillance](#)<sup>3</sup>

[Science Table Ontario Dashboard](#)<sup>4</sup>

[Local Public Health Units](#)<sup>5</sup>

#### **Q2. Is this technical brief usable in other settings outside of acute care where health care is provided, for example long term care, primary care, dental offices, congregate living settings (e.g., group homes, correctional facilities)?**

Yes. This technical brief is primarily intended for use by IPAC and occupational health professionals to provide an overview of the practical implementation of IPAC measures during the COVID-19 pandemic. It is acknowledged that these principles may be applied to varied settings where health care is provided including pre-hospital care, long term care, primary care, ambulatory care clinics and community care, including home care and congregate living settings. While those outside of acute care using the document are advised to consult with local public health and those with IPAC and occupational health expertise to understand risk assessment and application in their setting, comments have been provided throughout the technical brief about considerations when adapting to other settings. The recommendations and considerations provided on safely adjusting IPAC measures based on increasing or decreasing transmission risk have been designed to mitigate risk while being adaptable to balance the unique needs and characteristics of a diverse spectrum of health care organizations and regions (e.g., patient population, psychological health and safety needs, human resources, infrastructure, immunization coverage, legislative requirements).

#### **Q3. Why is universal masking for health care workers (HCW) still recommended in clinical areas during low risk of transmission periods? What are factors to consider when deciding whether to keep HCWs masked in non-clinical areas during low risk of transmission periods?**

Universal masking for source control in healthcare settings is associated with reduced transmission of COVID-19.<sup>6</sup> Patient populations in healthcare settings are generally more vulnerable to severe disease

than the general public and masking in clinical areas provides an added layer of protection for the patient population through all risk periods.

Consideration of a number of factors is helpful in deciding on whether to mask in non-clinical areas during low risk periods. These include measures of internal COVID-19 activity and evidence of nosocomial transmission (e.g., outbreaks in healthcare facilities, hospitalizations and ICU admissions, staff positivity rates and absenteeism) as well as the operational capacity of the organization (e.g., critical staffing shortages that could be affected by transmission between staff in non-clinical areas). It would also be important to consider the logistical challenges involved in removing and re-instating IPAC measures through risk periods (e.g. education, resources, funding). Risk tolerance will vary based on multiple dynamic factors and their unique circumstances.

**Q4. What should be considered when deciding whether to mask ambulatory patients during low risk of transmission periods? Why would a patient be asked to wear a mask in their bed space when receiving care?**

During high risk and transition periods, patient masking is recommended when patients are ambulatory (e.g., outpatients, inpatients or residents who are outside of their bed space) to reduce transmission within a health care facility. During low risk periods, considerations for masking ambulatory patients would include patient population with potential for higher likelihood of being infected with COVID-19 (e.g., unvaccinated, higher likelihood of presenting with viral respiratory illness such as paediatrics), patient population who may not be compliant/able to self-screen and balancing of psychosocial factors associated with masking in some populations (e.g., where the health care setting is the individual's home such as long term care residents). Also to consider would be logistical challenges with removing and re-instating protocols through various risk periods.

Patients may be asked to wear a mask in their bed space while receiving care based on the types of interactions with staff (e.g., prolonged close interactions) to provide source control as an added layer of protection.

**Q5. Why is active screening of patients for symptoms recommended even in low risk periods?**

Screening of patients for signs and symptoms of communicable diseases to identify potentially infectious individuals is part of Routine Practices. While active screening of patients is ideally performed at the point of entry into the facility, consideration can be given to passive screening at entry and then active screening performed upon arriving at the unit or clinical destination. Active screening of inpatients or residents is recommended at least once daily through all risk periods.

**Q6. Are there any limitations to social gatherings in the low risk period?**

Health care facilities should follow local public health guidelines for capacity limits for gatherings. Even during low risk periods, the impact of staff absenteeism should be taken into consideration in the event of an exposure during the gathering. Consideration should be given to wearing masks and limiting room occupancy to avoid crowding and distancing particularly when eating or drinking. In addition, food and drinks are not to be consumed in clinical areas (e.g., nursing station, patient care areas, laboratories).<sup>7</sup>

**Q7. Why is access limited to vaccinated essential caregivers and visitors during high and transition risk periods?**

Essential care givers and visitors may have prolonged close contact with patients. Vaccination including the primary series and all eligible booster doses is recommended for all individuals and is one of the strongest layers of protection in reducing risk of transmission to vulnerable patients in health care settings. Visitors should be screened for signs, symptoms and exposure in all risk periods regardless of vaccination status.

**Q8. Why should consideration be given to limit room occupancy to allow for physical distancing during gatherings and in break rooms/cafeterias during all risk periods?**

The 3Cs (Closed spaces, crowded places and close contact) can increase the risk of transmission of COVID-19 from an infectious individual in any risk period. The risk may be higher particularly in break rooms where staff are more likely to be unmasked while eating and drinking thereby without source control.

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## References

1. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Interim infection prevention and control measures based on COVID-19 transmission risks in health care settings [Internet]. Toronto, ON: Queen's Printer for Ontario; 2022 [cited 2022 Jun 15]. Available from: [https://www.publichealthontario.ca/-/media/Documents/nCoV/ipac/technical-brief-ipac-measures-transmission-risks.pdf?sc\\_lang=en](https://www.publichealthontario.ca/-/media/Documents/nCoV/ipac/technical-brief-ipac-measures-transmission-risks.pdf?sc_lang=en)
2. Ontario. Ministry of Health; Ontario. Ministry of Long-Term Care. COVID-19: guidance for the health sector [Internet]. Toronto, ON: Queen's Printer for Ontario; 2019 [modified 2022 Jun 15; cited 2022 Jun 15]. Available from: [https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019\\_guidance.aspx](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx)
3. Ontario Agency for Health Protection and Promotion (Public Health Ontario). COVID-19 data and surveillance [Internet]. Toronto, ON: Queen's Printer for Ontario; 2022 [cited 2022 Jun 15]. Available from: <https://www.publichealthontario.ca/en/data-and-analysis/infectiousdisease/covid-19-data-surveillance>
4. Jüni P, da Costa BR, Maltsev A, Katz GM, Perkhun A, Yan S, et al; Ontario COVID-19 Science Advisory Table. Ontario dashboard: tracking Omicron [Internet]. Toronto, ON: Ontario COVID-19 Science Advisory Table; 2021 [cited 2022 Jun 15]. Available from: <https://doi.org/10.47326/ocsat.dashboard.2021.1.05>
5. Ontario. Ministry of Health; Ontario. Ministry of Long-Term Care. Health services in your community: public health units [Internet]. Toronto, ON: Queen's Printer for Ontario; 2019 [modified 2022 Feb 14; cited 2022 Jun 15]. Available from: <https://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx>
6. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Universal mask use in health care [Internet]. Toronto, ON: Queen's Printer for Ontario; 2022 [cited Jun 2, 2022]. Available from: [https://www.publichealthontario.ca/-/media/Documents/nCoV/ipac/faq-covid-19-universal-mask-use-health-care.pdf?sc\\_lang=en](https://www.publichealthontario.ca/-/media/Documents/nCoV/ipac/faq-covid-19-universal-mask-use-health-care.pdf?sc_lang=en)
7. O Reg 67/93. Available from: <https://www.ontario.ca/laws/regulation/930067#:~:text=32.,are%20used%2C%20handled%20or%20stored.>

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