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FREQUENTLY ASKED QUESTIONS

(ARCHIVED) Frequently Asked Questions on Interim IPAC Recommendations for Use of PPE in Health Care Settings

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Introduction

As we learn more about Omicron, Public Health Ontario (PHO) has updated recommendations in its technical brief for infection prevention and control (IPAC) practices in health care settings: Interim IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID- 19.[1] These recommendations are interim and will be re-evaluated as more information on the Omicron variant and its lineages emerge.

The purpose of this document is to answer questions related to changes in IPAC recommendations and to help implement these changes in their workplaces.

PHO does not develop or approve public health policy or guidance, including those issued by the Chief Medical Officer of Health (CMOH) in accordance with the Health Protection and Promotion Act.[2]

Interim IPAC Recommendations

Q1: Why have the recommendations changed?

Early data on the Omicron variant and its lineages estimates an increased ability to transmit from person-to-person and lower protection from vaccines. As a result, all infection prevention and control measures within the hierarchy of controls should be optimized, particularly vaccination.

Q2: What has changed in the recommendations?

As we gather more evidence regarding Omicron and its lineages, the updated interim recommendations are for fit-tested, seal-checked N95 respirators (or equivalent or greater protection), eye protection, gown and gloves to be used for direct care of patients with suspect or confirmed COVID-19. Other appropriate PPE includes a well-fitted surgical/procedure (medical) mask or non-fit tested respirator,

eye protection, gown, and gloves for direct care of patients with suspect or confirmed COVID-19, based on individual risk assessment.

Fit tested N95 respirators (or equivalent or greater protection) should be used when aerosol generating medical procedures (AGMPs) are performed or anticipated to be performed on patients with suspect or confirmed COVID 19.

Q3: Who do these recommendations apply to?

These recommendations apply to all health care settings, health care workers (HCW), and other staff who work in health care settings. Health care settings include, but are not exclusive to, acute care, pre-hospital care, long-term care, primary care, ambulatory care clinics and community care, including home care and other locations in the community where health care is provided (e.g., residential care or correctional facilities).

In terms of care recipients, these recommendations apply to all patients/residents/clients who have been placed under additional precautions for suspect or confirmed COVID-19.

These are minimum recommendations; individuals and organizations may determine additional measures based on risk assessment.

Q4: What is the recommendation if our home/hospital/clinic is in short supply of N95 respirators?

Determine your estimated daily/weekly PPE usage (including use of N95 respirators). Supplies may be ordered by visiting the Ontario Government's PPE Supply Portal.[3] In the event of critical supply shortages, consideration can be given to reserving respirators for AGMPs and extended use of respirators.[4,5] Medical masks continue to be recommended as appropriate based on point of care risk assessment (PCRA).

Q5: Are vaccines still recommended as a protective measure against COVID-19?

Yes. Vaccines remain effective at preventing severe COVID-19. Enhancing vaccine effectiveness with recommended booster doses will provide increased protection for HCWs from COVID-19 and reduce infection from exposures in both the community and healthcare setting.

Q6: How can health care workers protect themselves?

Health care workers are at risk of COVID-19 infection from exposures in the workplace as well as in the community. That is why public health measures, particularly vaccination and other layered preventative measures such as staying home when sick, getting tested, masking, physical distancing and hand hygiene are important to prevent COVID-19 transmission both in the community and in health care settings.

The risk of COVID-19 infection for HCWs is influenced by multiple factors including:

- Local epidemiology
- Healthcare worker factors (e.g., immune status, hand hygiene)
- PPE practices (including choice, fit and appropriate donning and doffing)
- Patient factors (e.g., vaccination status, ability to mask for source control)
- Interaction (e.g., close, prolonged contact, procedures associated with higher transmission risk)

- Environmental factors (e.g., crowding and ventilation).

The protection of HCWs from COVID-19 requires multiple layers of prevention in healthcare and community settings aimed at reducing COVID-19 transmission. Health care workers can protect themselves by ensuring they conduct individual risk assessments prior to all interactions and tasks.

For more information on layers of prevention, see Public Health Ontario's How to Protect Yourself from COVID-19.[6]

Q7: Where relevant, should the "recommended PPE" (N95, etc.) and "other appropriate PPE" (medical mask, etc.) both be considered appropriate PPE for the purposes of risk-assessment of close contacts?

Yes, they would both be considered appropriate for the risk assessment. Interim recommendations include a fit-tested N95 respirator (or equivalent or greater protection), eye protection, gown and gloves for direct care of patients with suspect or confirmed COVID-19, and a well-fitted medical mask or non-fit tested respirator, eye protection, gown and gloves are also considered appropriate PPE based on individual risk assessment. Therefore, they are all considered appropriate PPE for the purposes of risk-assessment of close contacts.

As usual, the risk assessment of close contacts would involve multiple considerations other than the specific type of mask worn by the HCW, such as whether or not the HCW wore the PPE consistently and appropriately (e.g., for the duration of the care being provided), and the type and duration of the interaction.

Q8. What are the recommendations for extended use or re-use of N95 respirators to conserve the supply?

As per best practice, N95 respirators donned for providing care to an individual with suspect or confirmed COVID-19 are to be discarded upon leaving the patient/resident/client environment. Additionally, N95 respirators are to be discarded if they are visibly soiled, contaminated, damp, damaged or difficult to breathe through. In times of short supply, extended use (i.e., wearing continuously) is preferable to re-use (i.e., taking off and putting on repeatedly) because repeatedly doffing and donning a used respirator increases the risk of self-contamination and may affect the integrity and function of the mask.[7] Extended use of N95 respirators should only be considered during supply shortages and in consultation with your IPAC professional. Based on a risk assessment, there may be reasonable opportunities to extend the use of PPE safely. For example, staff entering the room with no direct interactions with the patient/resident/client may continue to wear their facial PPE (e.g., eye protection, N95 respirator/medical mask) after exiting the room. Conversely, if a health care worker is providing direct care to a patient/resident/client who is exhibiting symptoms (e.g., coughing) the potential for contamination of PPE is far greater than the previous example in which case the respirator should be changed. Wearing a cloth or medical mask over the N95 respirator to conserve the N95 is not recommended. If you do encounter a critical supply shortage, supplies may be accessed on an emergency basis through Digital Health Services.[8]

Q9. What type of medical mask is recommended?

The Interim IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or confirmed COVID-19 references medical or surgical/procedure masks with an ASTM level 1-3. The 3 classifications under the American Society for Testing and materials (ASTM) all have similar particulate filtration efficiency and are most different with respect to fluid resistance that may occur with body fluid splashes/splatters as experienced in health care settings.

- Level 1 (low) – e.g., venous pressure splash

- Level 2 (moderate) – e.g., arterial pressure splash
- Level 3 (high) – e.g., high-velocity procedures, orthopedic surgery

This means that any ASTM rating (1-3) is appropriate for COVID-19 and the level is mostly around splash protection. What is most important is that the mask is well-fitted and snugly covers the nose and under the chin without gaps. As always, individuals should conduct a point of care risk assessment (PCRA) or a personal risk assessment before each interaction and may determine that a higher level of personal protection is justified.[9,10]

Q10. The technical brief recommends a fit-tested N95 respirator or equivalent. What is meant by equivalent?

There are many different models of respirators on the market including KN95, FN95, FFP2, CAN95 and others. While some of these may meet standards for filter efficiency, not all models do. If a respirator model meets filtration criteria and the respirator is to be used as an N95 equivalent, wearers are required to have the respirator fit-tested. If the respirator does not meet filtration criteria, then it cannot be considered equivalent to a fit-tested N95, but could still be considered akin to a medical mask.[9] For more information regarding a list of approved medical devices for uses related to COVID-19 please visit Health Canada's Authorized Medical Devices for Uses Related to COVID-19: List of Authorized Medical Devices Other than Testing Devices.[11]

Q11. Where is the appropriate place to don and doff PPE?

A risk assessment must be done before each interaction with patient/resident/client or the environment in order to determine which personal protective equipment (PPE) is required to prevent transmission during the interaction. PPE should be donned (put on) just prior to the interaction typically just outside the patient room and the PPE should be doffed (removed) and disposed of in the appropriate receptacle following the interaction. Ideally, PPE should be removed immediately at the exit of the patient/resident/client space. However if there is a lack of space (e.g., less than 2 metre distance from the client/patient/resident), staff may remove gown and gloves within the room at the exit and then exit the room and remove facial protection which includes mask/respirator and eye protection just outside the room.

Some considerations regarding the donning and doffing area would be a) alcohol based hand rub is easily accessible b) appropriate receptacles i.e., garbage for disposable PPE, bin for linen if cloth gowns are used and c) waste receptacles are not adjacent to clean supplies to avoid contamination.[12]

Q12. What are the PPE recommendations for screeners?

Consider having a designated area for screening. Screening generally involves transient distanced interactions, typically with masked individuals and does not often involve close or direct contact.

For those conducting screening **not** involving direct contact:[1]

- If able to maintain spatial distance of at least 2 m or separation by physical barrier, Routine Practices is appropriate which currently includes universal medical masking for healthcare workers.
- If unable to maintain spatial distance of at least 2 m or separation by physical barrier, appropriate PPE includes a well-fitted medical mask, isolation gown, gloves and eye protection.

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