

COVID-19 Outpatient Office Guidance

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Etiology

Coronaviruses are a large family of viruses that are common in many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS), and now with COVID-19.

Cases of COVID-19 were initially linked to exposure to live animals at a seafood market in China but the substantial increase in cases thereafter is due to human-to-human transmission of the virus.

Clinical Presentation

COVID-19 includes clinical features that present in varying type, frequency, severity and within different age groups. Published reports often over-represent individuals who have more severe symptoms and these may differ across care settings and between different age groups. Symptoms that are absent at the onset of illness may develop over time with disease progression. To date, there is no comprehensive list of symptoms that has been validated to have high specificity or sensitivity for COVID-19. It is possible, that as new variants emerge there may be changes in the patterns of symptoms that individuals display. Clinical diagnosis should therefore always be confirmed through SARS-CoV-2 laboratory testing. Patients should always be encouraged to seek medical consultation if experiencing new or worsening symptoms. Common, less frequent and rare symptoms are listed in Table 1.

Table 1: Common, less frequent and rare symptoms for adults with COVID-19*

Common symptoms >50%	Less frequent (≤ 50%)	Rare symptoms (<10%)
<ul style="list-style-type: none">• fever• chills• new or worsening cough• fatigue and myalgia• headache• gastrointestinal symptoms (nausea, vomiting, diarrhea)	<ul style="list-style-type: none">• shortness of breath or difficulty breathing• sore throat• painful and/or difficulty swallowing• conjunctivitis• new or unusual exacerbation of chronic conditions• delirium• decreased or loss of appetite• new loss of smell and/or taste	<ul style="list-style-type: none">• skin manifestations• confusion• runny/stuffy nose• eye manifestations
<p>*Note: It is important to evaluate whether the patient’s symptoms are new, worsening, or different from their baseline.</p>		

Signs and Symptoms of COVID-19

Fever

The frequency of fever varies amongst studies but remains one of the primary symptoms of COVID-19. A patient may not

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present with a fever, but may develop a fever after a few days of experiencing other symptoms. Older adults and those with underlying comorbidities may experience fever and respiratory symptoms later during the course of illness, when compared to younger persons or those without comorbidities.

Cough and shortness of breath

Other more prevalent symptoms that have been reported include cough and shortness of breath. Cough is one of the most prevalent symptoms along with fever. Both dry (58%) and productive (25%) coughs have been described in the literature. Shortness of breath was more frequently reported in hospitalized patients and associated with more severe disease.

Other symptoms

Many other symptoms have been associated with COVID-19. Of particular note, fatigue, myalgia, and loss of taste and/or smell are experienced in about 1/3 of all cases. Some uncommon symptoms found in COVID-19, but reported during acute illness include congestion or runny nose, skin rashes and eye issues (including conjunctivitis, eye pain and light sensitivity). These other symptoms do not typically occur on their own, and are found in conjunction with the more prevalent symptoms. Some of the more uncommon symptoms may also become more prevalent as new variants emerge. Two rare but important syndromes associated with SARS-CoV-2 have been described in the literature and are called Multisystem Inflammatory Syndrome – Children (MIS-C) and Multisystem Inflammatory Syndrome – Adults (MIS-A). These are described below.

Multisystem Inflammatory Syndrome – Children (MIS-C)

In early 2020, this syndrome in children was newly recognized as related to SARS-CoV-2 infection and characterized by hyper inflammation and multi-organ involvement, and presenting with clinical features similar to Kawasaki disease and toxic shock syndrome.

MIS-C signs and symptoms include:

- Kawasaki disease-like features: conjunctivitis, red eyes; red or swollen hands and feet; rash; red cracked lips, and swollen glands. In some children, coronary artery enlargement and/or aneurysms have been described. Some children presenting with Kawasaki disease-like syndrome have been noted to have a broader age range and presentation with more gastrointestinal (abdominal pain or diarrhea) and neurologic (headaches or meningitis) manifestations
- Gastrointestinal symptoms such as abdominal pain, diarrhea, nausea/vomiting (patients have presented with colitis, hepatitis, and questionable appendicitis)
- Toxic shock syndrome-like features with hemodynamic instability and poor heart function. Cytokine storm/macrophage activation or hyper inflammatory features
- Thrombosis or acute kidney injury
- Shortness of breath

Common laboratory findings in case reports have included:

- An abnormal level of inflammatory markers in the blood, including elevated ESR/CRP and ferritin, LDH
- Lymphopenia, thrombocytopenia, neutrophilia
- Elevated B-type natriuretic peptide (BNP) or NT-proBNP (pro-BNP), hyponatremia, elevated D-dimers

In children presenting with a persistent fever (≥ 3 days) who are moderately to severely ill with clinical signs of organ dysfunction (e.g. gastrointestinal, respiratory, cardiac, skin, or neurologic), the diagnosis of MIS-C should be considered.

Multisystem Inflammatory Syndrome – Adults (MIS-A)

Since June 2020, several case reports and series have been published reporting a similar multisystem inflammatory

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syndrome in adults (MIS-A) that was previously identified in children. Three studies identified 27 patients who had cardiovascular, gastrointestinal, dermatologic, and neurologic symptoms without severe respiratory illness and who also have positive test results for SARS-CoV-2 by PCR or antibody assays indicating recent infection. Clinicians should consider MIS-A in adults with similar signs and symptoms as seen with MIS-C. It is important to note that 30% of adults and 45% of children with MIS-C/A reported a negative PCR and a positive SARS-CoV-2 antibody test results, suggesting MIS-A and MIS-C might represent a post-infectious process. If suspicious of MIS-C/A and a patient has a negative PCR test, consider both antibody and viral testing to assist with diagnosis.

COVID-19 Disease Symptoms Other Populations

Symptoms in children

A recent systematic review of the signs and symptoms of laboratory-confirmed COVID-19 disease in children and youth under 19 years of age found cases of asymptomatic positive laboratory tests ranged from 15% to 42%. Fever and cough were the most common symptoms; with the proportions with fever ranging from 46% to 64% and for cough from 32% to 56%. All other signs and symptoms were present at less than 10% to 20%. Vomiting, diarrhea and abdominal ranged from 7% to 18%. One should also consider when assessing children, that the signs and symptoms of COVID-19 are similar to those of other infections and non-infectious processes, including influenza, other viral upper respiratory infections, streptococcal pharyngitis, asthma and allergies. The lack of specificity of signs or symptoms and the significant proportion of asymptomatic infections make symptom-based screening for identification of SARS-CoV-2 infection in children difficult.

Symptoms in older adults

Symptoms amongst older adults may be atypical or subtle. Confusion, delirium, and/or loss of movement, mobility and speech may occur in older people. Fever, cough and shortness of breath may be absent or less common.

Symptoms in older adults that differ from typical symptoms include:

- fever and other symptoms may take longer to manifest
- delirium, confusion, falls, functional decline
- decrease in blood pressure
- hypoxia without respiratory symptoms

Asymptomatic, pre-symptomatic and pauci-symptomatic infection

A person who is **asymptomatic** is someone with a positive SARS-CoV-2 test who never develops any symptoms, whereas a person who is **pre-symptomatic** is someone who is infected with SARS-CoV-2 and may have detectable virus, but is not yet showing symptoms (these individuals develop symptoms later on in the course of infection). Individuals who are **pauci-symptomatic** will have a positive SARS-CoV-2 test in the presence of very limited symptomatology. A systematic review and meta-analysis looking at prevalence of SAR-CoV-2 in persons who are asymptomatic from 28 studies, found that 25% of COVID-19 cases were asymptomatic (95%CI: 16–38). Asymptomatic, pre-symptomatic and pauci-symptomatic SARS-CoV-2 infection and how much each of these contributes to transmission is still unknown.

Diagnosis

Diagnosis is made by isolation of the virus in a mid-turbinate, nasopharyngeal swab, throat and mouth gargle for PCR and sent to the provincial lab for a confirmatory result. Abbot ID Now point of care (POC) anterior nasal testing may be completed as a screen but a positive result must be confirmed by PCR.

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Epidemiology

Reservoir

Early on, many of the patients in the outbreak of respiratory illness caused by COVID-19 in Wuhan, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread.

Transmission

The understanding of COVID-19 transmission has evolved since the beginning of the pandemic and has informed the public health measures (PHM) used in Canada. Infected individuals generate respiratory droplets and aerosols, which can be transmitted to others. Activities that are more likely to generate respiratory droplets and aerosols include: heavy breathing (e.g., during exercise), talking, singing, shouting, coughing, and sneezing. The droplets vary in size from large droplets that may fall to the ground relatively quickly near the person who is infected, to small droplets called aerosols which may remain suspended in the air and travel on ambient air currents. The risk of transmission via respiratory aerosols is greater in poorly ventilated indoor environments where there is a high density of people and extended duration of contact. The relative infectiousness of droplets of different sizes, and the amount of virus in respiratory droplets needed to cause infection (i.e., infectious dose), is not clear.

Infectious droplets or aerosols may come into direct contact with the mucous membranes of another person's nose, mouth, or eyes, or they may be inhaled into the nose, mouth, and airways, with smaller aerosols penetrating deeper into the lungs. The virus may also spread when a person touches another person (e.g., a handshake) or an object (referred to as fomites) that has the virus on it, and then touches their mouth, nose, or eyes with unwashed hands.

Other factors that may affect the transmission of COVID-19 are age, infectiousness, presence of symptoms, illness severity, and characteristics of the virus itself (e.g., variant of concern [VOC]), as well as adherence to personal preventive practices, such as physical distancing, proper use of well-constructed and well-fitting masks, hand hygiene, and respiratory etiquette. There is no evidence to date to suggest differences in mode of transmission of circulating VOC.

Environmental factors, settings, and specific activities can contribute to the risk of viral transmission, including enclosed spaces, especially those with poor ventilation, crowded settings, and close interactions. Settings where these factors overlap or involve activities such as singing, shouting or heavy breathing (e.g., aerobic exercise) are considered higher risk. Examples of these settings include family gatherings and other social gatherings, religious services, funerals, and choir practices, as well as in occupational settings including health care facilities and meat processing plants. The duration of exposure in such settings is also likely to increase the risk of transmission. It is exceedingly important that PHM be applied in a “layered” manner in these settings to reduce the risk of transmission.

Incubation Period

The incubation period for COVID-19 has been estimated to range from 2 to 14 days, with a median of 5-6 days from exposure to symptom onset. Of all individuals who develop symptoms, 97.5% of the symptoms occur within 11.5 days of exposure and 75% will develop symptoms between 6.7 and 8.5 days.

Period of Communicability

The time period in which an individual with COVID-19 can transmit the virus is said to be at a maximum of 10 days after symptom onset for immunocompetent people who have COVID-19. Evidence has shown that an individual may be infectious for up to 3 days prior to any presentation of symptoms. The levels of viral RNA from nasopharyngeal, saliva/sputum samples, upper respiratory specimens, and stool samples appear to be highest soon after symptom onset.

Note that SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset. However,

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detection of viral RNA does not necessarily mean that the patient can transmit the virus. For this reason, patients should not be tested for COVID-19 until 8 weeks has passed since initial diagnosis.

A recent systematic review and meta-analysis found that SARS-CoV-2 cases with serial upper respiratory tract samples showed peak viral loads within the first week of symptom onset. The highest viral loads were reported soon after or at the time of symptom onset or at day 3–5 of illness, followed by a consistent decline.

Disease severity and risk factors for severe disease

There is a spectrum of COVID-19 disease severity, ranging from asymptomatic to mild, to moderate, severe and critical disease. Severe disease more often occurs in those with increasing age and those with underlying medical conditions, with the risk increasing with the number of underlying conditions.

Two large cohort studies in the USA and the UK found the most common comorbidities were hypertension (46.7%), hyperlipidemia (28.9%), diabetes (27.9%), and chronic pulmonary disease (16.1%). High risk for mortality was associated with increasing number of comorbid conditions. A comprehensive CDC scientific evidence review process and a Canadian rapid review have recently been published to update the list of underlying medical conditions associated with more severe COVID-19 disease.

Cases and contacts

In general isolation for a COVID case is 10¹ days after symptoms began or since the positive test, as long as the infected person feels well and is not taking any immunosuppressive therapies.

Close contacts of a case will isolate for 14 days from the last contact with the case.

Vaccination:

- Covid-19 vaccines are strongly recommended for healthcare workers who do not have a contraindication
- There are currently no recommended changes to IPC practices regardless of vaccination status
- Public Health Agency of Canada (PHAC) will continue to monitor data on vaccine effectiveness including against circulating Variants of Concern (VOC).

Infection Prevention and Control Preparedness

Each outpatient facility or office should be prepared to identify and manage or direct patients appropriately who have been exposed, suspected or confirmed to have COVID-19.

Application of Routine Practices including Point of Care Risk Assessment (PCRA) and Additional Precautions

Routine Practices

Routine Practices are based on the premise that all clients/patients/residents are potentially infectious, even when asymptomatic, and that the same safe standards of practice should be used routinely with all clients/patients/residents to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms.

Routine Practices (Appendix B) apply to all staff and patients, at all times, in all healthcare settings, and

¹ Viable virus has not been obtained from a recovered case infected with COVID after 10 days post symptom onset or positive test result. 14 days of isolation for contacts is still required since the incubation of the virus can be up to 14 days.

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include but are not limited to:

- Conducting a PCRA (Appendix A)
- Hand hygiene
- Adhering to respiratory hygiene

Point of Care Risk Assessment

A point of care risk assessment (PCRA) assesses the task, the patient and the environment. A PCRA is a dynamic risk assessment completed by the HCW before every patient interaction in order to determine whether there is risk of being exposed to an infection. Performing a PCRA is the first step in Routine Practices, which are to be used with all patients, for all care and for all interactions. A PCRA will help determine the correct PPE required to protect the health care worker in their interaction with the patient and patient environment. Health care workers (HCWs) should use a risk assessment approach before and during each patient interaction to evaluate the likelihood of exposure.

A PCRA (Appendix A) includes determining if there may be:

- Contamination of skin or clothing by microorganisms
- Exposure to blood, body fluids, respiratory secretions or excretions
- Exposure to contaminated equipment or surfaces
- Exposure to AGMPs

PCRA is not a new concept, but one that is already performed regularly by professional HCWs many times a day for their safety and the safety of patients and others in the healthcare environment. For example, when a HCW evaluates a patient and situation to determine the possibility of blood or body fluid exposure or chooses appropriate PPE to care for a patient with an infectious disease, these actions are both activities of a PCRA.

The selection and use of PPE during patient interactions should always be determined by the PCRA (Appendix A).

Personal Protective Equipment

All PPE (e.g., gloves, gowns, medical masks, eye protection) should be supplied in adequate amounts and sizes in all patient care areas, and placed so it is readily accessible at the point-of-care for all staff.

Training should be provided, with posters clearly outlining the steps for putting on and removing PPE posted for visual cues inside and outside each room of a patient on Contact and Droplet Precautions (Appendix C).

All Staff using PPE should:

- Be trained and tested on and monitored for compliance.
- Perform a PCRA (Appendix A) prior to entering and ongoing while in a patient's room.
- Select and put on PPE as per the PCRA (Appendix A) and prior to entering the room of a patient on Additional Precautions.
- Ensure that their PPE fits properly, is worn appropriately, and provides adequate coverage.

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- Consistently follow the correct methods for putting on and removing PPE, so that self-contamination or contamination of the environment is prevented.
- Perform hand hygiene before putting on, during, and after removal of PPE.

Additional Precautions

In addition to the consistent application of Routine Practices (Appendix B), a minimum of Contact and Droplet Precautions (Appendix C) should be implemented with all suspect or confirmed COVID-19 patients. This includes the appropriate selection and use of **all** the following personal protective equipment (PPE):

- Gloves
- Long-sleeved cuffed gown (covering the front of the body from neck to mid-thigh)
- Medical mask
- Eye protection (full face shield that covers the front and sides of the face or well-fitting goggles)
- Hand hygiene should be performed whenever indicated, paying particular attention to before donning PPE, during and after removal of PPE, and after leaving the patient care environment.

After seeing a patient on Contact and Droplet Precautions:

- Gloves, gowns, eye protection and masks should be discarded into the nearest no-touch waste receptacle.
- Hand hygiene must be performed during and after PPE removal and between patient encounters.
- The area where PPE is put on should be separated as much as possible from the area where it is removed and discarded.

Environmental cleaning and disinfection

Cleaning and disinfection of high-touch surfaces is important for controlling the spread of microorganisms.

- Environmental disinfectants should be classified as hospital disinfectants, registered in Canada with a Drug Identification Number (DIN), and labelled effective for both enveloped and non-enveloped viruses.
- Manufacturer's instructions for use and required contact times should be followed to ensure adequate disinfection.
- All patient exam room surfaces that are considered high touch (e.g. examination table/bed, bedrails, chair arms, charting desks or tables, touch screens, keyboards, hand washing sink handles) surfaces should be cleaned and disinfected between each patient.
- Single use barriers or covers (e.g., paper table covers) used on surfaces that are more likely to become contaminated should be discarded after each patient, and underlying surfaces cleaned and disinfected.
- Cleaning and disinfecting of low touch surfaces (e.g., shelves, chairs or benches, windowsills, message or white boards, outside of sharps containers) should also be performed on a regular basis and when soiled.
- Floors and walls should be kept visibly clean and free of spills, dust and debris.
- Patient exam rooms and all central areas should be kept free of clutter to facilitate cleaning.
- Remove all toys, magazines and books from the waiting room.
- Increase cleaning and disinfection of the waiting area and high traffic areas.
- All surfaces or items outside of the patient room that are touched by or in contact with staff (e.g., computer carts, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) should be cleaned and disinfected at least daily and when soiled. Staff should ensure that their hands are clean

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before touching the above mentioned equipment.

- In areas with patients who are considered exposed to, or suspected or confirmed to have COVID-19, or shared staff or patient common spaces, more frequent cleaning and disinfection is required.

Handling Patient Care Equipment

- Single use disposable equipment and supplies should be used whenever possible, and discarded into a no-touch waste receptacle immediately after use.
- All reusable equipment should, whenever possible, be dedicated for use by one patient. If reuse with other patients is necessary, equipment (e.g. blood pressure cuff, stethoscope) should first be cleaned and then disinfected with a hospital grade disinfectant according to the manufacturers recommended contact time.
- Items that have been cleaned and disinfected should be clearly identified and stored separately from non-clean and non-disinfected items.

Early Recognition and Source Control

Outpatient and ambulatory care facilities should ensure that a consistent process is in place for screening all patients. It should include on arrival assessment of patients for signs and symptoms of COVID-19, a suspected or confirmed diagnosis of COVID-19, or any recent contact with a person suspected or confirmed to have COVID-19.

Policies and procedures are in place to prevent the introduction of COVID-19 and to prevent and control the spread of infection if identified. Policies and procedures include:

- A hand hygiene program
- Environmental cleaning and disinfection policies and procedures
- Application of Additional Precautions- Contact and Droplet Precautions (Appendix C) based on a Point of Care Risk Assessment (PCRA) (Appendix A)
- Staff are provided training, time, guidance (donning and doffing procedures) and support to properly put on and remove PPE after encounters with patients
- Work exclusion for staff with exposures to, and those with suspected or confirmed, COVID-19.
- Non-punitive sick leave
- Staff is prepared to offer virtual visits to patients via telephone or web-based communication, where clinically appropriate and in-person assessment is not necessary

The term “staff” is intended to include anyone working in outpatient and ambulatory care settings, including but not limited to those providing health care.

To facilitate early recognition and source control:

Signage is posted at all points of access to instruct staff, patients and visitors to:

- Not enter if they have been instructed to self-isolate or self-quarantine until cleared by Public Health
- Practice hand hygiene
- Practice respiratory hygiene
- Put on a mask or medical grade mask upon entry

All staff, patients and visitors are actively screened for signs and symptoms of and recent exposure to COVID-19 prior to entry.

Staff will:

- Triage (Appendix D) for identification of symptoms or risk factors and appropriate placement (source control) of

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patients.

- Perform a PCRA (Appendix A) prior to any interaction with a patient or visitor.
- Ensure screening is active and passive (signage) (Appendix E).
- Ensure medical grade masks, tissues and ABHR be available at all entrances.
- Post signage (Appendix E) to instruct symptomatic patients to alert healthcare workers, thus prompting completion of a patient screening questionnaire.

If a person is triaged and has symptoms of COVID-19 or:

- Has been in close contact with a probable or confirmed case of COVID-19
- Has been in close contact with an individual with COVID-19 symptoms

THEN the following actions should be taken:

- If physician office visit is required then book an appointment. Follow appropriate Infection Prevention and Control guidelines (Droplet and Contact Precautions) (Appendix C).
- Patients with signs or symptoms of, or potential exposures to, COVID-19 should be instructed to perform hand hygiene and put on a medical mask, and immediately placed under a minimum of Contact and Droplet Precautions (Appendix C) in a single room with the door closed.
- Posters illustrating the correct method for putting on and removing PPE should be displayed for visual cues, inside and outside of each room of a patient considered exposed to, or suspected or confirmed to have, COVID-19.
- All staff who enter the room, or come within 2 meters, of a patient who is considered exposed to, or suspected or confirmed to have COVID-19, wear gloves, gown, medical mask, and eye protection, in addition to following Routine Practices (Appendix B).
- Signage that indicates a minimum of Contact and Droplet Precautions (Appendix C) is placed outside of exam rooms where patients are waiting and who are a potential exposure, suspect, or confirmed COVID-19 case.
- If a patient does not fall into the above categories, request the patient wear a mask and wash hands when entering the office.

Linen Management

Routine Practices should be used.

Waste Management

Routine Practices should be used.

Infection Prevention and Control Guidelines

[Infection prevention and control for coronavirus disease \(COVID-19\): Interim guidance for acute healthcare settings](#)

[Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings](#)

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[Hand Hygiene Practices in Healthcare Settings](#)

[Infection prevention and control for COVID-19: Interim guidance for outpatient and ambulatory care settings](#)

[Reopening your Practice during COVID-19](#) (CMA)

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Appendix A: Point of Care Risk Assessment

Prior to any patient interaction, all health care workers (HCWs) have a responsibility to always assess the infectious risk posed to themselves and to other patients, visitors, and HCWs. This risk assessment is based on professional judgement about the clinical situation and up-to-date information on how the specific healthcare organization has designed and implemented engineering and administrative controls, along with the availability and use of Personal Protective Equipment (PPE).

Point of Care Risk Assessment (PCRA) is an activity performed by the HCW before every patient interaction, to:

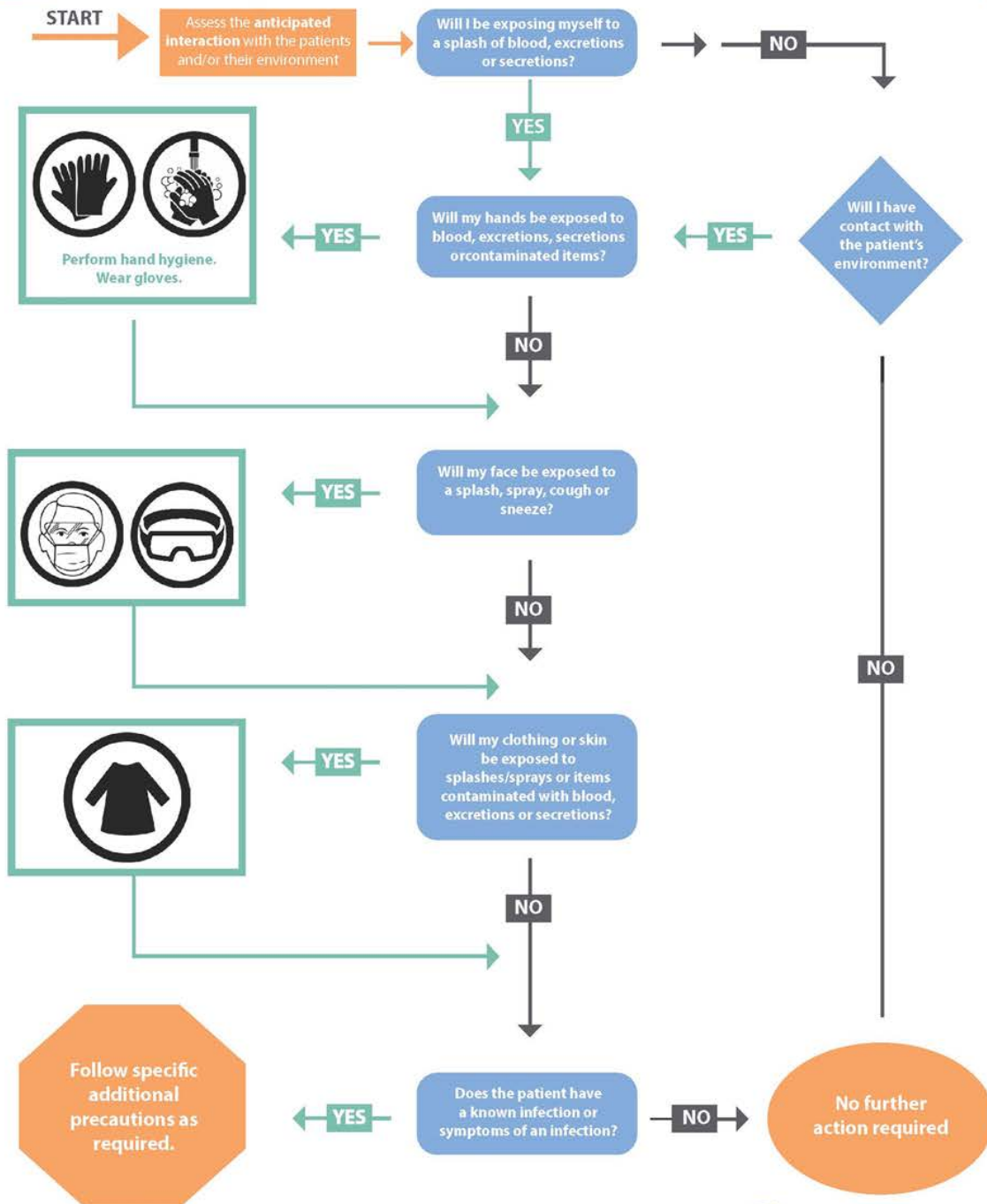
1. Evaluate the likelihood of exposure,
 - a. From a **specific interaction** (e.g., performing/ assisting with clinical procedures/ interaction), non-clinical interaction (i.e., admitting, teaching patient/ family), transporting patients, direct face-to-face interaction with patients, etc.)
 - b. with a **specific patient** (e.g., residents not capable of self-care/ hand hygiene, have poor-compliance with respiratory hygiene, copious respiratory secretions, frequent cough/ sneeze, early stage of illness, etc.)
 - c. **specific environment** (e.g., single rooms, shared rooms/ washrooms, hallway, assessment areas, emergency departments, public areas, therapeutic departments, diagnostic imaging departments, housekeeping, etc.)

AND

2. Choose the appropriate actions/ PPE needed to minimize the risk of patient, HCW/other staff, visitor, contractor, etc. exposure to COVID-19

PCRA is not a new concept, but one that is already performed regularly by professional HCWs many times a day for their safety and the safety of patients and others in the healthcare environment. For example, when a HCW evaluates a patient and situation to determine the possibility of blood or body fluid exposure or chooses appropriate PPE to care for a patient with an infectious disease, these actions are both activities of a PCRA.

Routine Practices Risk Assessment + Algorithm for all Patient Interactions



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Appendix B: Routine Practices

Routine Practices are based on the premise that all clients/patients/residents are potentially infectious, even when asymptomatic, and that the same safe standards of practice should be used routinely with all clients/patients/residents to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms

Routine Practices reduce the risk of exposure to blood, body fluids and broken skin and when used correctly will protect you and others from germs and diseases that can spread from person to person.

Point of Care Risk Assessment

Health care providers must assess the risk of exposure to blood, body fluids and non-intact skin and identify strategies that will decrease exposure risk and prevent the transmission of microorganisms. Choose the most appropriate routine practice for the situation.

Hand Hygiene

Clean hands stop the spread of germs and prevent infection. Use alcohol based hand rub (ABHR) when hands are not visibly dirty. ABHR should be rubbed between all surfaces of your hands for 15 seconds.

Perform hand hygiene according to the four moments:

- Before contact with the patient or their environment
- Before performing an aseptic procedure
- After a body fluid exposure risk
- After contact with the patient or their environment

Personal Protective Equipment (PPE)

PPE includes medical grade gloves, gowns, masks and protective eye wear.

Control of the Environment

Controlling the environment includes measures that are built into the infrastructure of the health care setting that have been shown to reduce the risk of infection to staff and clients/patients/residents. This includes administrative controls, such as appropriate accommodation and placement of patient care equipment that is in good repair and effective cleaning practices for equipment and the environment. Engineering controls, such as dedicated hand washing sinks, point-of-care ABHR and sharps containers, and sufficient air changes per hour appropriate to the care setting, are the preferred controls as they do not depend on individual health care provider compliance

Environmental Cleaning

Germs are spread from unclean surfaces to hands of health care providers, clients, patients, residents and family. Any surface can be contaminated, even when there is no visible soiling. It is extremely important to clean surfaces that have been contaminated. Remember to clean patients/residents/clients care equipment between uses. Always clean up spills of blood or body fluids as soon as possible. If surface is visibly soiled, clean before disinfecting.

Safe Sharps Handling

Sharp objects like needles and razors must be disposed of at point of use in a puncture resistant container. Never try to recap used needles or pick up sharps with your bare hands.

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Administrative Controls

Administrative controls are measures that the health care setting puts into place to protect staff and clients/patients/residents from infection.

Staff Education and Training

Infection Prevention and Control (IPAC) education should be provided to all staff, especially those providing direct client/patient/resident care, at the initiation of employment as part of their orientation and as ongoing continuing education on a scheduled basis. IPAC education must span the entire health care setting and be directed to all who work in that setting.

Respiratory Etiquette

Health care settings should reinforce with staff, clients/patients/residents and visitors the personal practices that help prevent the spread of microorganisms that cause respiratory infections.

These personal practices include:

- not visiting in a health care facility when ill with an acute respiratory infection,
- avoidance measures that minimize contact with droplets when coughing or sneezing, such as:
 - turning the head away from others
 - maintaining a two-metre separation from others
 - covering the nose and mouth with tissue
 - immediate disposal of tissues into waste after use and immediate hand hygiene after disposal of tissues

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Appendix C: Contact and Droplet Additional Precautions

Contact and Droplet Precautions

Suspected or Confirmed Resident with Respiratory Illness (Influenza-like Illness, Influenza, COVID-19) follow Contact/ Droplet Precautions. This includes the appropriate selection and use all of the following personal protective equipment (PPE).

- Gloves
- Long-sleeved gown
- Facial protection, such as a surgical/procedure mask and eye protection/ face shield, or surgical/procedure mask with visor attachment

All PPE should be removed before leaving the patient's room and discarded into a no-touch receptacle.

Donning PPE Order

1. Perform hand hygiene
2. Don gown
3. Apply mask
4. Apply face shield or goggles
5. Put on gloves

Doffing PPE Order

1. Remove gown and gloves (can be removed together)
2. Perform hand hygiene
3. Remove face shield or goggles (do not touch the front)
4. If appropriate remove mask touching only the strings or ear loops.
5. Perform hand hygiene

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Appendix D: Triage and Source Control

Primary Care providers are an important role in the identification, referral and response to suspected or confirmed COVID-19 patients.

Sample Screening: Completed by signage at entrance and at arrival by staff.

Is the patient experiencing:

1. Fever: Single temperature equal to or $> 38^{\circ}\text{C}$ or feeling feverish
2. Any new or worsening respiratory symptoms (cough, shortness of breath or difficulty breathing, runny nose or sneezing, nasal congestion, sore throat or difficulty swallowing) OR
3. Any new onset non-respiratory symptoms including chills, muscle or body aches, fatigue or weakness, gastrointestinal symptoms (abdominal pain, diarrhea, vomiting), headache, new loss of taste or smell or other unexplained symptoms or change in clinical status

And/Or any of the following:

OR Close contact with a confirmed or probable case of COVID-19

OR Close contact with a symptomatic individual

If symptoms or risk factors and they require physician care then book an appointment. Follow appropriate Infection Prevention and Control guidelines (**Routine Practices with the addition of Droplet and Contact Precautions**).

If symptoms are severe then refer to the nearest Emergency room. Let the receiving hospital know of the patient referral and risk factors.

Symptomatic Patient or Risk Factors for COVID who requires a Primary Care Physician Assessment

On arrival to office:

Have patient don a **medical grade mask**

Have patient complete hand hygiene

Immediate placement in an exam room with the door closed.

Healthcare worker will follow **Routine Practices with the addition of Droplet and Contact precautions**

Appendix E: Signage



Please tell the receptionist or Nurse if you are:

Experiencing cough, shortness of breath, fever/chills, sore throat, congestion, sneezing, loss of sense of smell or taste, diarrhea, unusual fatigue, headache and/or muscle aches.

OR

Have been in contact with an individual diagnosed with COVID-19 or an individual symptomatic of COVID-19.

Please wash your hands as you enter our office with the provided Alcohol Based Hand Rub. If you have symptoms or risk factors of COVID-19 please put on a medical grade mask.

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Appendix F: Office Precautions

Appointments

1. Patients should be screened at arrival. Signage (Appendix E) should prompt patients to communicate symptoms and risk factors to staff.
2. Allow for physical distancing of patients in the waiting room.
 - Arrange waiting room chairs to maintain physical distancing.
 - Patients who can, should wait in their cars until called for their appointment
3. Request patients come alone to appointment unless support is needed.

Non-urgent Patient Needs

1. Prescription refills can be completed by phone or fax.

Other:

1. Keep the glass at the reception window closed.
2. Place patients in exam room as soon as possible.
3. Posts signs at entrance requiring patients with COVID-19 symptoms and/or risk factors to self-identify to staff.
4. Review Infection Prevention and Control procedures with all staff.

PPE, surface cleaners and disinfectants are available and accessible at all points of care.