Frequently Asked Questions (FAQ): COVID-19 (2019-nCoV)

March 13, 2020 – UPDATES

1. Why did the additional precautions required for patients suspected and confirmed to have COVID-19 change?

   On March 12, 2020, Public Health Ontario changed the additional precautions required for the routine care of patients suspected or confirmed to have COVID-19 to Droplet and Contact precautions. **Please note: all aerosol generating medical procedures (AGMP) for patients suspected or confirmed to have COVID-19 must be carried out under Full precautions (Airborne, Droplet and Contact precautions).** The decision was made by the Ministry of Health in consultation with recommendations from the World Health Organization and Public Health Ontario and was based on a better understanding of the epidemiology and droplet/contact transmission of the virus, along with the spectrum of illness that it causes.

February 20, 2020 - UPDATES

1. What do we know about the clinical profile of COVID-19 patients?

   Our current understanding (as of February 20, 2020) is that anyone can become infected with COVID-19, although fewer infections are reported in children compared to adults. According to a Chinese study involving a cohort that included more than 44 000 confirmed COVID-19 patients, about 81% of infections presented with mild symptoms, similar to a cold or flu. 14% of patients developed severe symptoms such as pneumonia and 5% required critical care support. The overall case fatality rate was 2.3%. Those with advanced age (i.e. age over 60 years) and other health conditions, such as heart disease, diabetes, chronic lung disease, hypertension, and cancer, were at increased risk for death. These findings are generally consistent with what we see with other respiratory viruses.

February 14, 2020 - UPDATES

1. Why does the case definition keep changing?

   We are monitoring the case counts and secondary transmission across the globe daily to determine the level of risk in different areas. As the numbers increase in countries other than China, we may need to include them in the case definition for screening. Furthermore, we may need to revise the clinical symptoms in the case definition as we learn more about the characteristics of this disease. This is an expected process for a newly evolving disease. Please refer to this COVID-19 intranet site to ensure you have the most up to date case definition, screening tools and documents.

February 14, 2020 - UPDATES

1. <u>What is the risk of novel coronavirus transmission within healthcare facilities?</u>

   With the proper use of personal protective equipment (PPE), current data suggest the risk of transmission of nCoV within healthcare settings is low. A recent case series of a 1099 patients with nCoV in China reported that only 2% of cases were healthcare workers. Another publication including 138 nCoV cases in a single Wuhan, China hospital revealed concerning findings that 41% of cases were presumed to be healthcare associated. However, the report did not comment on the consistency of appropriate PPE use or the use of aerosol-generating medical procedures associated with these cases (AGMP). Improper PPE use or the use of AGMP can increase the risk of nCoV transmission. Furthermore, there have not been any documented cases of healthcare associated transmission in North America.

January 31, 2020 FAQ

1. <u>What is the current status of the novel virus, and does it pose a threat to patients and employees at UHN?</u>

   Please consult the latest Situation Report for COVID019 (2019-nCoV) issued by the World Health Organization (WHO) here.

2. <u>What measures is UHN taking to prevent transmission of the virus?</u>

   At UHN, we perform enhanced screening of patients at points of entry to the hospital, including clinics and Emergency Departments. Specifically, we aim to promptly identify patients who have signs and symptoms of the infection along with travel to the affected areas. Patients who screen positive will be placed on full precautions (airborne/droplet/contact isolation) and rapid viral testing will be initiated. The details of this process can be further provided by the ED and clinic managers, depending on the location you are working in. UHN IPAC is in close contact with Public Health Ontario and other agencies to help guide decision making and receive updates on the virus. We continue to encourage all employees to adhere to routine practices which includes monitoring patients for new onset of symptoms, diligent hand hygiene practices, appropriate use of personal protective equipment (PPE) and disinfection of shared equipment.

   Regarding UHN visitors and staff, we have pre-existing signage and policies regarding not attending the hospital when ill with respiratory virus symptoms. These policies should be reinforced by clinical and administrative staff. Routine masking in and outside the hospital is not needed.

3. <u>What do we know about human-to-human transmission?</u>

   Like other human coronaviruses, the novel coronavirus is thought to be transmitted via large droplets generated by coughing, sneezing and spitting. There have been documented instances of human-to-human transmission with this novel coronavirus,

including transmission from patient to healthcare worker. All transmission events have thus far occurred in Wuhan (as far as we know) and none outside the country. Although this may imminently change, this is the most up to date information we currently have. We remain vigilant and will isolate all patients with suspected infection using full precautions.

4. How is this infection similar to SARS?

Similarities to SARS include that both viruses are coronaviruses, a group of viruses known to also cause common colds, but also sometimes pneumonias. Both SARS and this novel virus originated in China and likely came from animals. The main differences between the two – from what we currently know about the novel coronavirus - is that the mortality rate from SARS was higher and the level of transmission was higher as well.

Compared to the state of public health and infection prevention and control during the SARS outbreak in 2003, we now have far better communication across the city/country/globe, more rapid viral testing, better screening, more infrastructure for infection control programs across the country and at UHN, and more policies in place to prevent transmission. We are in a far better state to face this challenge than we were during the SARS outbreak. Therefore, the likelihood of an outbreak similar to the one seen due to SARS is low.

5. Is there a vaccine available for this infection, and what can we do to protect ourselves from the infection?

No vaccination is available for this infection at this time. It is unlikely that the influenza vaccine has any influence on acquiring this novel virus. Because influenza is a deadly and highly contagious virus, we encourage all employees to get the flu shot annually.

6. What is the incubation period of the virus? How do you know that those currently infected will not infect others? That's what we kept hearing with SARS and it wasn't accurate.

The incubation period is unknown. Healthcare agencies have been using a conservative estimate of 14 days, consistent with other coronaviruses. Human to human transmission has been reported in China. For this reason, we have instituted screening processes in the ED and clinics and encourage all employees to adhere to routine practices, hand hygiene, and proper use of PPE. No cases have been confirmed in Canada so far.

7. What is the risk of human-to-human transmission of the novel coronavirus?

Based on the best available information, there have been confirmed human-to-human transmission events. We believe that transmission between people has been limited because all of the infected individuals have thus far originated from Wuhan (as far as we know). Although this may imminently change, this is the most up to date information we currently have.

8. <u>How will UHN prevent spreading of virus beyond asking patients about their travel history? As a public place there is high turnaround of people beyond patients (family members with positive travel history, contractors, visitors...) who are not necessarily educated about the virus risk.</u>

   We have pre-existing signage and policies regarding ill visitors and employees that should be followed as usual. These policies should be reinforced by clinical and administrative staff.

9. <u>Will additional resources be devoted to the Housekeeping department to increase wipe-down frequencies of high traffic surfaces? I.e. door handles, elevator buttons, stair rails, cafeteria surfaces?</u>

   Resources are being mobilized as needed. Housekeeping is aware and responding.

Document change History:

Date	**Change Description**
February 11, 2020	Added Risk of nCoV transmission within healthcare facilities.
February 14, 2010	Updated title to COVID-19. Added Case definition changing.
February 20, 2020	Added COVID-19 clinical profile to date.
March 13, 2020	Added additional precautions update.