

College of Chiropractors of Ontario

COVID-19 Pandemic Clinical Practice Directive

Version 3.0- May 26th, 2020

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Version History

Release Date	Source	Change(s)
May 14th, 2020	COCOO COVID-19 Pandemic Clinical Practice Directive	<ul style="list-style-type: none"> Initial release
May 19th, 2020	COCOO COVID-19 Pandemic Clinical Practice Directive	<ul style="list-style-type: none"> Chiropractors and Podiatrists are no longer under the requirement to provide only urgent care as an essential service New Introduction section with information on provision of Essential Care
May 26th, 2020	COCOO COVID-19 Pandemic Clinical Practice Directive Version 3.0	<ul style="list-style-type: none"> Updated with information from substituted Directive # 2 issued on May 26th, 2020 New Introduction section with information on substituted Directive #2 Addition of Context subsection Revision of Preamble section New guidance on screening essential visitors Update to screening: Active and Passive New guidance on Organizational and Point of Care Risk Assessments New guidance on Managing the Clinical Schedule Expansion on provision of Virtual Care Guidance on sourcing PPE New guidance on Environmental Adaptations Addition of Health Human Resources New guidance on Staff Illness Addition of Appendix

Introduction

Updated: May 26th, 2020

The following document has been updated to provide Members of the College of Chiropractors of Ontario (COCOO) guidance to ensure a safe gradual restoration of all deferred and non-essential and elective services subject to the requirements of substituted Directive #2 issued on May 26th, 2020.

In the gradual restart of services, Members must comply with the requirements as set out in COVID-19 Operational Requirements: Health Sector Restart (May 26th, 2020 or as current), including, but not limited to, the hierarchy of hazard controls.

This directive is intended to outline measures that must be in place in order to meet COCOO standards and advisories, public health guidelines, and promote a safe environment for the provision of in-person health services by Members.

Context

On March 19th, 2020, the Chief Medical Officer of Health issued Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals) as part of the response to the COVID-19 pandemic. This Directive required that all non-essential and electives be ceased or reduced to minimal levels, subject to allowable exceptions, until further notice.

On May 26th, 2020 Directive #2 was amended to support the gradual restart of all deferred and non-essential and elective services carried out by Health Care Providers (HCPs). Where possible HCPs are encouraged to limit the number of in-person visits for the safety of health care providers and their patients.

This COCOO directive is an addendum to the COCOO [Infection Prevention and Control Standard](#) and the COCOO [Technical Review Advisory Relating to COVID-19](#) updated on April 23, 2020.

The [Technical Review Advisory Relating to COVID-19](#) and the [PPE Checklist v2](#) **MUST** be completely reviewed and applied before you can open your practice to the public.

Members are responsible to ensure that any and all staff have read and are able to ask questions regarding this directive. Staff must be trained and audited on the implementation of all policies and procedures. Auditing could involve, but is not limited to a sheet that can be signed or use of a training log, as a form of confirmation that documents were reviewed.

Note to Chiropractors and Podiatrists: This directive is current as of the date of publication and reflects the rules and requirements for Chiropractors and Podiatrists. In the event of a discrepancy between this information and the directives of provincial public health authorities, the directives of the provincial public health authority take precedence.

As regulated health professionals, Chiropodists and Podiatrists are required to:

Follow all mandates and recommendations from Public Health and the Government of Ontario regarding your personal and professional conduct.

As a regulated health professional, you have a fiduciary responsibility to follow all civil orders that originate from any level of government.

Read and adhere to all communication from the COCOO.

The COCOO continues to consult with external stakeholders, including the Ministry of Health and the Chief Medical Officer of Health (CMOH) and will adapt this directive based on expert recommendations. The COCOO exists to protect the public and its members, and this directive is created to ensure that the health and safety of both the public and Members while instilling patient confidence as they safely access Chiropody and Podiatry care.

Check the Ministry of Health (MOH) COVID-19 Website regularly for updates to COVID-19 Operational Requirements: Health Sector Start, case definition, testing guidance, the latest 'COVID-19 Reference Document of Symptoms', 'COVID-19 Patient Screening Guidance Document', other guidance documents, mental health resources, and other COVID-19 related information

Preamble

Under Directive #2, Members must consider which services and treatments should continue to be provided remotely and which services and treatments can safely resume in-person with appropriate hazard controls and sufficient PPE.

Since the onset of the COVID-19 Pandemic, the following updates have been provided to Members and remain in place. The following updates can also be found in [Technical Brief PPE \(V2\)](#), April 23, 2020.

- Triple screening of ALL patients (enhanced)
- Continued treatment of only patients without symptoms of COVID-19 or Acute Respiratory Infections (ARI)
- Continued use and monitoring of engineering and administrative control measures
- Continued organizational and point of care risk assessment (enhanced)
- Adapting standard precautions with additional droplet precautions (use of gloves, mask, and eye protection) at all times in consultation/treatment room
- Use of contact precautions (use of gloves, mask, gown, and eye protection) only when indicated from outcome of risk assessment
- Implementation of universal masking for patients in order to receive Chiropody and Podiatry Care
- Continued hand hygiene by patient upon entering and exiting the practice/clinic
- Extended use of procedure/surgical masks
- Extended use and reprocessing of reusable goggles/eye wear/face shield protection

Requirements

This directive includes requirements regarding:

1. Screening
2. Risk Assessments
3. Hand Hygiene
4. Environmental Cleaning and Disinfection
5. Physical Distancing
6. Use of PPE
7. Exclusion or Work Restrictions during Staff or Member Illness

Patient Screening

Members must assess and screen patients for symptoms of COVID-19 as per the requirements of Public Health Ontario. Patients exhibiting signs and symptoms consistent with COVID-19, should **NOT** present for clinical services during the pandemic.

If a patient or essential visitor screens positive over the phone or at check in for appointment, the appointment should be deferred and the individual referred for testing.

For reference, a full list of common COVID-19 symptoms is available in the COVID-19 Reference Document for Symptoms on the MOH COVID-19 website. Atypical symptoms and signs of COVID-19 are also included in this document and should be considered, particularly in children, older persons, and people living with a developmental disability.

Active Screening

Patients and essential visitors (e.g., parents, caregivers, interpreters) should be screened over the phone for symptoms of COVID-19 before coming for their appointments. The latest COVID-19 Patient Screening Guidance Document on the MOH COVID-19 website should be used and may be adapted as needed and appropriate for screening purposes.

Upon arrival for appointment patients and essential visitors **MUST** be screened with the same questions as the patient. Staff should conduct screening of patients and essential visitors on site. Staff should ideally be behind a barrier to protect them from contact/droplet spread. A plexiglass barrier can protect reception staff from sneezing/coughing patients. If a plexiglass barrier is not available, staff should maintain a 2-metre distance from the patient. Screeners who do not have a barrier and cannot maintain a 2-metre distance should use contact/droplet precautions. This includes the following PPE: gloves, isolation gown, a surgical/procedure mask, and eye protection (goggles or face shield).

Clinic Sign-In Log

A registry of all people entering the clinic should be kept to aid in contact tracing if required.

This could be implemented by documenting caregivers/family members present for patient's appointment within the appointment scheduler.

This would include people in the clinic aside from patients who would remain in the clinic for an extended period of time (i.e. contractors, students).

This is not an open sign-in book and should be kept and managed privately by the clinic.

This registry would be kept while this directive remains in place to facilitate contact tracing in case of an outbreak.

Note: Visitor logbooks are required for facilities as part of Occupational Health & Safety.

What if...

a Member encounters a patient or an essential visitor who has gone through the screening process and enters a treatment room yet **still exhibits signs and symptoms consistent with COVID-19**, the Member must:

- o Establish and maintain a safe physical distance of two metres
- o Have the patient or essential visitor perform hand hygiene
- o Provide a new mask for the patient or essential visitor to don
- o Segregate the patient or essential visitor from others in the clinic
- o Explain the concern that they are symptomatic, discontinue treatment and reschedule
- o Advise the patient or individual they should self-isolate and call local Public Health immediately
- o Clean and disinfect the practice area immediately¹

Members must not attempt a differential diagnosis of patients who present with signs and symptoms of COVID-19.

Members are required to call their [local Public Health Ontario](#)² unit to receive guidance if they are aware of a patient or companion who has visited their clinic within the last 14 days and is now testing (or has tested) positive for COVID-19. Patients should be referred for further assessment and support for COVID-19 (referral to Primary Care Physician, Telehealth (1-866-787-0000), Self-Assessment Tool, etc.).

This information is current as of the date effective and may be updated as the situation on COVID-19 continues to evolve.

Passive Screening

Signage should be posted at the entrance to the office/clinic and at reception areas requiring all patients/essential visitors to wear a face covering (if tolerated), perform hand hygiene, and then report to reception to self-identify.³

Signage should be accessible and accommodating to patients and essential visitors (e.g., plain language, pictures, symbols, languages other than English and French).

Sample signage is available on the MOH COVID-19 [website](#).

Fact sheets on [how to wear a mask](#) and [how to perform hand hygiene](#) are available on the Public Health Ontario (PHO) website.

¹ <https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/environmental-cleaning>

² <http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx>

³ http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_signs_EN_patients.pdf

Screening Questions for all Patients and Essential Visitors⁴:

Patients and/or essential visitors exhibiting symptoms should **NOT** receive treatment at this time and should be directed to call Public Health.

See Appendix A for Regular Screening Questions (as of May 17th, 2020)

COVID-19 Screening Results

If response to <u>ALL</u> of the screening questions is <u>NO</u> :	<i>COVID-19 Screen Negative</i>
If response to <u>ANY</u> of the screening questions is <u>YES</u> :	<i>COVID-19 Screen Positive</i>

COVID-19 Patient Screening Guidance Document is subject to updates. Member is encouraged to check with Ministry of Health for any changes to screening process. Latest guidance documents for screening are available at [MOH Website](#).

Testing

Testing for COVID-19 has been expanded significantly since onset of pandemic. Updates from the Ministry of Health now recommend testing for COVID-19 to be undertaken for all patients as per below.

- Symptomatic testing:
 - **All patients with at least one symptom** of COVID-19, even for mild symptoms. Please refer to the Testing Guidance for details about these symptoms.
- Asymptomatic risk-based testing:
 - **Patients who are concerned that they have been exposed to COVID-19.** This includes people who are contacts of or may have been exposed to a confirmed or suspected case.
 - **Patients who are at risk of exposure to COVID-19 through their employment,** including essential works (e.g., health care workers, grocery store employees, food processing plants).

Members should refer to the latest Testing Guidance and patients who meet criteria should be referred for testing (Assessment Centre, Telehealth (1-866-787-0000), Primary Care Provider, etc.). Depending on location of Assessment Centre, patients may be able to self-refer and may no longer require a referral done by their Primary Care Provider.

4

http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_patient_screening_guidance.pdf

If a patient was in the health care setting and later tests positive for COVID-19, Members, if aware, are encouraged to call their local public health unit for advice on their potential exposure and implications for continuation of work.

Risk Assessments

Organizational Risk Assessment

Each Health Care Entity should conduct an organizational risk assessment (ORA) as a precondition to restarting services. An ORA is a systematic approach to assessing the efficacy of control measures that are in place to mitigate the transmission of infections in a health care setting.

Organizations that employ HCPs (including Chiropractors and Podiatrists) have a responsibility to provide education and training to HCPs regarding the organization's ORA.

Point of Care Risk Assessments (PCRAs)

The first step in the effective use of Routine Practices is to perform a risk assessment. A risk assessment is a thought process that assesses the task, the patient, and the environment. Members must perform a PCRA before each interaction with a patient or their environment (in case of home/LTC visits) to determine whether there is a risk to the provider or other individuals of being exposed to an infection, including COVID-19.

The risk assessment is performed in order to determine appropriate intervention and interaction strategies, such as hand hygiene, waste management, use of personal protective equipment (PPE) and patient placement, that will reduce the risk of transmission of microorganisms to and from the individual.

A Point-of-Care Risk Assessment (PCRA) specifically is the place where three elements occur together: the patient, the Member and treatment involving patient contact.

Assessing Risk of Transmission

The following factors can affect the risk of transmission of microorganisms in clinical settings. The Member must perform a risk assessment of each task or interaction that includes assessing the risk of:

- Contamination of skin or clothing by microorganisms in the patient's environment (for home/LTC visits)
- Exposure to blood, body fluids, secretions, excretions, tissues
- Exposure to non-intact skin
- Exposure to mucous membranes
- Exposure to contaminated equipment or surfaces

FAQs on PCRAs

When is a PCRA used?

A PCRA must be performed by every health care provider before every patient interaction.

The PCRA, along with clinical and professional judgement and evidence-based recommendations, supports the selection of appropriate PPE. It should be completed on an ongoing basis assessing the following:

- How susceptible is the patient to infection?
- Is their immune system intact?
- Does the patient have any invasive devices or open areas?
- What is the risk of exposure to blood, body fluids, microorganisms, mucous membranes or non-intact skin in the task about to be performed?
- Does the patient have a new undiagnosed rash?
- Does the patient have any drainage or leakage not contained in a dressing and/or medical appliance?
- How competent is the Member in performing the task?
- How cooperative will the patient be while the task is performed?

What are some additional considerations for Chiropody and Podiatry risk assessments?

- Are you able to maintain 2 metres distance from the patient?
 - *If no, COCOO requires routine practices with droplet precautions (eye protection and mask)*
- Are you performing a surgical procedure? Or do you anticipate a splash of a bodily fluid or potential contact with respiratory droplets?
 - *If no, COCOO requires routine practices with droplet precautions (eye protection and mask)*
 - *If yes, the additional precaution of CONTACT be used- you would need to wear a gown*
- Do you anticipate contact with debris from nail/callous care?
 - Examine your positioning at point of care, are you able to perform it standing to reduce contact with debris?
 - Is wearing an apron appropriate? Use of lap towel? Does your chair have a tray at point of care to collect debris?
 - What is my clinical attire? Is it easily cleaned? Should I wear a lab coat as a means of source control and covering of my skin?

Members must assess the risk of exposure to blood, body fluids and non-intact skin and identify the strategies that will decrease exposure risk and prevent the transmission of microorganisms. This risk assessment followed by the implementation of Routine Practices to reduce or remove risk should be incorporated into the culture of each clinical setting and into the daily practice of each Member.

Is there training available for how to perform a PCRA?

For more information regarding point-of-care risk assessment, there are additional training modules available from Public Health Ontario IPAC Core Competencies.

[Public Health Ontario: At A Glance: Infection Prevention and Control Fundamentals](#)

The IPAC training most specific to your question would be, however all IPAC Core Competencies build on one another for a comprehensive IPAC approach:

[IPAC Core Competencies: Personal Risk Assessment in Community Care - Clinic](#)

Modules are free and upon completion you will receive a certificate that can be documented as part of your COCOO Continuing Education.

Hand Hygiene

Hand hygiene is recognized as the single most important infection prevention and control (IPAC) practice to break the chain of transmission of infectious diseases, including respiratory illness such as COVID-19.

Hand hygiene can be accomplished by either washing hands with soap and water and then drying with single use cloth or paper towels or using alcohol-based hand sanitizer. Alcohol-based hand sanitizer must be approved by Health Canada (DIN or NPN number), with a final concentration of 60-80 percent ethanol or 60-75 percent isopropanol. When hands are visibly soiled, they must be cleaned with soap and water as opposed to using alcohol-based hand rub.

Single use cloth towels that are used in the clinic for hand hygiene must be laundered in hot water (above 60°C) with regular laundry soap and fully dried before being used again. Staff that is handling towels should be gloved for both dirty and clean laundry processing. Staff should use new gloves when handling clean laundry.

A significant component of hand hygiene is not touching your face. In addition to proper hand hygiene, Members and staff must also avoid touching their face and practice respiratory etiquette by coughing or sneezing into their elbow or covering coughs and sneezes with facial tissue and then disposing of the tissue immediately. When contact with the face or a tissue is made, hand hygiene must occur before resuming any activities in the clinic environment.

Hand hygiene is required to be performed by:

Members when:

- entering the clinic
- before contact with each patient
- before clean/aseptic procedures
- after body fluid exposure or risk of body fluid exposure
- after contact with each patient
- after contact with a patient's surroundings or belongings
- before donning PPE
- after donning PPE
- after doffing PPE
- after cleaning contaminated surfaces

Staff when:

- entering the clinic
- before interaction with a patient
- before clean/aseptic procedures
- after body fluid exposure or risk of body fluid exposure
- after interaction with a patient
- before donning PPE
- after doffing PPE
- after cleaning contaminated surfaces
- after financial transactions or administration of paperwork involving patients

Patients and Essential Visitors when:

- entering the clinic
- entering the treatment area if the patient does not proceed directly to a treatment room
- before and after use of shared equipment
- prior to processing payment

Environment Cleaning and Disinfection

Effective cleaning and disinfection are essential to avoid the possible spread of COVID-19, which is spread through contact with respiratory droplets or contact with contaminated surfaces. The COVID-19 virus can survive for different periods of time depending on the surfaces it is on. Frequent cleaning and disinfection are necessary to prevent spread of the disease.

Cleaning products remove soiling such as dirt, dust and oils, but do not always sanitize surfaces. Disinfectants are applied after cleaning to sanitize resulting in the destruction of germs.

Members must read, understand, and apply the cleaning standards from the Health Canada guide on cleaning and disinfecting public spaces during COVID-19.

In addition to procedures for environmental cleaning as part of your standard [PHO Core Elements](#), environmental cleaning protocols should be reviewed due to COVID-19. This will help determine where improvements or additional cleaning may be needed.⁵ Environmental cleaning procedures must be established and documented within your office policy and procedures book. A minimum of twice daily disinfection of high touch surfaces is required.⁶ An organizational risk assessment is required to determine facility needs, as well as policies and procedures specific to environmental cleaning and disinfection. Special considerations and revisions should be in place when the facility is operating during the pandemic.



⁵ <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/cleaning-disinfecting-public-spaces.html>

⁶ <https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/environmental-cleaning>

Create a Cleaning Procedure⁷

- After every patient visit, patient-contact surfaces (i.e., areas within 2 metres of the patient) should be disinfected as soon as possible, and before another patient is seen.
- Treatment areas, including all horizontal surfaces, and equipment used on the patient (e.g., shockwave, goniometer, thermometer) should be cleaned and disinfected before another patient is brought into the treatment area or used on another patient.
- All common areas should be regularly cleaned (e.g., daily) following PHO's guidance on cleaning and disinfection for public settings. In addition:
- Plexiglass barriers are to be included in routine cleaning (e.g., daily) using a cleaning product that will not affect the integrity or function of the barrier.
- Operators of community settings should develop or review protocols and procedures for cleaning public spaces. This will help determine where improvements or additional cleaning may be needed.
- Read and follow manufacturer's instructions for safe use of cleaning and disinfection products (i.e. wear gloves, use in well-ventilated area, allow enough contact time for disinfectant to kill germs based on the product being used).
- Wash hands with soap and water or use alcohol-based hand sanitizer after removing gloves.
- Use damp cleaning methods such as damp clean cloths, and/or a wet mop. Do not dust or sweep which can distribute virus droplets into the air.
- Contaminated disposable cleaning items (i.e. mop heads, cloths) should be placed in a lined garbage bin before disposing of them with regular waste. Reusable cleaning items can be washed using regular laundry soap and hot water (60-90°C). Clean and disinfect surfaces that people touch often.
- In addition to routine cleaning, surfaces that are frequently touched with hands should be cleaned and disinfected more often, as well as when visibly dirty.
- Shared spaces such as kitchens and bathrooms should also be cleaned more often.

Proper Disinfectant Products

Disinfectants with an 8-digit Drug Identification Number (DIN) are approved for use by Health Canada. Only products that are found on the [Disinfectants for Use Against SARS-CoV-2 \(COVID-19\) list](#) with a viricidal claim are appropriate for the elimination of viruses in the clinic environment. The disinfectant product manufacturer's instructions must be followed for use, safety, contact time, storage and shelf life.

Staff must take appropriate precautions when using chemicals for cleaning and disinfecting. This can be done by consulting the Manufacturer's Safety Data Sheets when using cleaners and disinfectants. Staff must be supplied with the appropriate safety equipment (gloves and surgical masks) to protect themselves when they clean and disinfect.

The frequency of cleaning and disinfection is dependent on the nature of use/contact of the surface/item in question.

Patient care/patient contact items MUST be cleaned and disinfected between each patient/use.

⁷ <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/cleaning-disinfecting-public-spaces.html>

Examples of patient contact items include but are not limited to:

- All clinical spaces, all contact surfaces including treatment chairs, operator chairs, etc.
- Therapeutic tools and devices (i.e. ECSWT, Laser, Ultrasound equipment)
- Diagnostic tools and devices
- Procedural work surfaces
- Discontinue use of any permanent treatment material that cannot be cleaned and disinfected (for example, upholstered cloth waiting room chairs)

Commonly touched areas MUST be cleaned and disinfected before and after every patient contact.

Commonly touched areas include but are not limited to:

- Light switches, doorknobs, toilets, taps, handrails, counter tops, touch screens/mobile devices, phones and keyboards
- The payment machine must be cleaned after each patient encounter (contactless payment methods encouraged)
- Clipboards that patients contact must be disinfected after each patient encounter.
- Stationary used by patients must be disinfected after each patient use or be single-use only

Required Clinic Environment Adaptations

*these should already be in place as per the *Technical Review Advisory Relating to COVID-19*

- Books, magazines, toys and remote controls and other non-essential items must be removed from ALL patient areas (e.g., waiting room, treatment rooms).
- Non-essential items are recommended to be removed from patient care areas to minimize the potential for these to be contaminated and become a potential vehicle for transmission
- Discontinue patient-accessible literature displays and only directly dispense to patients or move to electronic distribution.
- Self-serve candy dish, baked goods and other open or unsealed consumables are not permitted.
- Provide tissues and lined garbage bins for use by staff and patients. No-touch garbage cans (such as garbage cans with a foot pedal) are preferred
- Ensure there are enough supplies on hand for proper hand hygiene, including pump liquid soap in a dispenser, running water, and paper towels or hot air dryers. If possible and appropriate, consider adding alcohol-based hand rub (ABHR) stations throughout the setting. Use ABHRs with 60%-90% alcohol.
- Post signage throughout the office reminding staff and patients about the signs and symptoms of COVID-19, and the importance of proper hand hygiene, physical distancing, and respiratory etiquette.

Physical Distancing

Requirements for Managing Clinical Space:

- Ensure that there is sufficient space to follow physical distancing guidelines of maintaining at least 2 metres from other people.
 - Redesign physical settings and interactions to minimize contact between individuals where possible (e.g., space out chairs in the waiting room, consider traffic flow for common spaces, limit the number of people in an elevator, place markings in hallways, install plexiglass barriers at reception, establish an alternative service delivery site).
 - Minimize the need for patients/visitors to wait in the waiting room (e.g., spread out appointments, have patients stay outside office/clinic until the examination room is ready for them).
 - People who live together and caregivers and companions that are required to attend with patients are exempt from this requirement
 - Face masks are to be worn by patients and essential visitors for entire duration in clinical space. Ensure that patients do not leave their masks in waiting areas.
- Physical distancing requirements take priority over occupancy limits.
- Walk-in patients are discouraged at this time in order to prevent crowding
- Reception and payment area-If two metres cannot be maintained at reception/payment area, either staff must be continuously masked or the installation of a plexiglass or plastic barrier must occur to protect reception staff.
- The treating practitioner must be two metres from the public when conversing.
- Discourage patients' family and friends from entering the clinic unless they are deemed to be an essential visitor by the patient and the Member.
- Restrict access to the practice environment to those who must be present, including patients, patient chaperones or essential visitors, and staff members.
- Occupancy and gathering limits include all individuals in the office, including staff.
- To aid in physical distancing, give consideration to having patients wait in vehicle until their appointment time. **It is prudent to have a contingency plan in place to avoid overcrowding.**

Managing the Clinical Schedule:

Subject to the requirements of Directive #2, *Members are in the best position to determine which services and treatments should continue to be provided remotely (online, by telephone or other virtual means) and which should be provided in-person. This should be guided by best clinical evidence. Members must also continue to adhere to the guidance from the College and the following principles (see Appendix B).*

Decisions regarding the gradual restart of services should be made using processes that are fair to all patients.

Virtual Care

- Virtual practice is encouraged to continue whenever possible.
 - e.g., online, phone consultations, virtual assessments, etc.
- Members are encouraged to implement a system for virtual and/or telephone consultations when and where possible.

Triage In-Office Appointments

- Pre-appointment triage protocols should be implemented in order to prioritize patient appointments. Patients could be screened for priority need based on a number of factors (presence/absence of pain, change in sensation, change in vascular status, history of ulcerations, comorbidities present, current signs of infection, new/suspicious lesions).
- Triage protocols will vary based on patient population seen in clinic and implementation of protocol should ensure fair and consistent booking practices.

Screening

- Triple screening (at time of booking, passive signage, and at check in) must be followed to prevent asymptomatic but exposed (i.e. close contact with confirmed positive, recent travel) or sick patients from attending in person.
- Patients who are COVID-19 positive are NOT to be treated at this time and should be rescheduled once clearance obtained from public health.

Booking Practices

- Ensuring that booking practices (duration of treatment visits and number of patients in the practice at any given time) comply with ongoing CMOH directives on group gatherings and occupancy limits.
- Booking practices must enable physical distancing between patients during treatment sessions and provide adequate time to clean and disinfect clinic equipment
- Protocols implemented to manage the flow of patients in and out of the practice environment can include: Staggering of appointments to ensure time for patient arrival, treatment, payment and exit as well as appropriate time for cleaning and disinfection before arrival of the next patient is required.⁸
- To limit contact, future appointments, receipts and payments can be procured over the phone or by electronic means. If done at reception, the 2-metre distancing must be adhered to, and proper disinfection must follow.

Refer to COCOO [COVID-19- Administrative and Engineering Controls](#)

(Updated April 23, 2020)

Signage

- As previously mentioned, passive screening signage will be at entrance of clinic for patients/staff.
- It is recommended that infection control procedures also be posted for reassurance of the public to demonstrate that steps have been taken to ensure the safest environment

⁸ <http://cocoo.on.ca/wp-content/uploads/2020/04/Administrative-and-Engineering-Controls-April-23-FINALv2.pdf>

possible (i.e. universal masking, hand hygiene requirements, disinfection protocols implemented)

- It is recommended that office rules highlighting any changes to regular office practices due to COVID-19 are also posted in order to better manage patient expectations (i.e. Payment types accepted, arrival on time (not early) for appointment, physical distancing)
- Signage should be available in primary languages spoken by your patient population.



Personal Protective Equipment

Personal protective equipment (PPE) is an essential element and last line of defence in preventing the transmission of disease-causing microorganisms. If used **incorrectly**, PPE will fail to prevent transmission and may facilitate the spread of disease. Education on donning and doffing must be provided to all staff and signage for guidance on use is recommended to be posted.

As per Directive #2, Members should be sourcing PPE through their regular supply chain. PPE allocations from the provincial pandemic stockpile will continue. PPE can also be accessed, within available supply, on an emergency basis through the established escalation process through the Ontario Health Regions.

Members will need to conserve the use of PPE in their clinics through the application of the hierarchy of hazard controls (**see Appendix C**).

PPE requirements

- A point-of-care risk assessment (PCRA) must be performed by Chiropractor and Podiatrist before every patient interaction.
- When Member is unable to maintain 2 metres distance in treatment room and for all treatments, Member must use DROPLET precautions in addition to standard precautions: mask, eye protection (face shield and/or goggles/safety glasses), gloves
- Determine with PCRA whether CONTACT precautions also need to be followed as per COCOO Infection Prevention and Control Standard

Modified Summary of Required Precautions and PPEs (based on COVID-19 Operational Requirements: Health Sector Start):

Activity	Health Care Provider (HCP) Precautions
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Before every patient interaction	HCP must conduct a point-of-care risk assessment to determine the level of precautions required
All interactions with and within 2 metres of patients who screened POSITIVE	STOP! DO NOT TREAT Droplet and Contact precautions: <ul style="list-style-type: none"> • Surgical/procedural mask • Isolation gown • Eye protection (goggles or face shield) • Perform hand hygiene before and after contact with the patient and the patient environment and after the removal of PPE
All interactions with and within 2 metres of patients who screened NEGATIVE and are at a high risk for additional CONTACT precautions	Droplet and Contact precautions: <ul style="list-style-type: none"> • Surgical/procedural mask • Isolation gown • Eye protection (goggles or face shield) • Perform hand hygiene before and after contact with the patient and the patient environment and after the removal of PPE
All interactions with and within 2 metres of patients who screened NEGATIVE	Droplet precautions: <ul style="list-style-type: none"> • Surgical/procedural mask • Eye protection (goggles or face shield) • Perform hand hygiene before and after contact with the patient and the patient environment and after the removal of PPE

If PPE equipment is limited, extended use of surgical masks can be done for the duration of the shift. If mask is removed at any time during the shift, the Member will need to replace it with a new mask. Masks must be discarded and replaced when wet, damaged or soiled, when taking a break, and at the end of the day. N95 respirators are not required. Cloth masks for Member use are not permitted as they are not approved for health-care settings.

PPE masks must be donned and doffed using the following specific sequence to prevent contamination. See *Resources* for PHO document on donning and doffing.

It is essential that all Members and staff providing services in a clinic are aware of the proper donning and doffing of PPE. The use of PPE must be precise and ordered to limit the spread of COVID-19.

IPAC and PHO Resources must be reviewed and understood before all Members and staff provide patient care. Training and practice of donning and doffing PPE within your facility are essential to ensure the proper use of PPE in support of limiting the spread of COVID-19.

Optimization Strategies for PPE:

Optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency strategies can help stretch PPE supplies when shortages are

anticipated, for example if members have enough supplies now but are likely to run out soon. Crisis strategies can be considered during severe PPE shortages and should be used with the contingency options to help stretch available supplies for the most critical needs.

As PPE availability returns to normal, members should promptly resume standard practices^{9,10}.The following temporary measures could be considered independently or in combination, depending on the local situation:

- I. PPE extended use (using for longer periods of time than normal according to standards)
- II. Reprocessing followed by reuse (after cleaning or decontamination/sterilization) of either reusable or disposable PPE)
- III. Considering alternative items compared with the standards recommended by WHO

Eye Protection:

The use of eye protection is required as part of droplet precautions as follows:

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

¹⁰ <https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/what-we-know>

- Disposable face shields, goggles, and visors (attached to surgical masks) that are disposed after each patient interaction is the optimal choice¹¹
- Reusable goggles, safety glasses (trauma glasses) with extensions to cover the side of the eyes, face shields (must be designed to cover the side of the face and to below the chin) that are removed after each patient treatment and reprocessed is the second choice
- Extended use of disposable face shields, goggles, and visors (attached to surgical masks)
- Alternative –local production of face shields (risk is suboptimal quality, including inadequate shape to ensure face protection)

Reprocessing of reusable eye protection:

- The reuse of eye protection without appropriate decontamination/ sterilization is strongly discouraged.
- Clean goggles, safety glasses, face shields with soap/detergent followed by disinfection using either sodium hypochlorite 0.1% (followed by rinsing with clean water) or 70% alcohol wipes.
- Goggles, safety glasses, face shields may be cleaned immediately after removal and hand hygiene is performed OR placed in designated closed container for later cleaning and disinfection.
- Ensure cleaning of eye protection takes place on a clean surface by disinfecting the surface before cleaning of eye protection
- Appropriate contact time with disinfectant (i.e. 10 minutes when using sodium hypochlorite 0.1%) should be adhered to before reuse of goggles, safety glasses, face shields.
- After cleaning and disinfection, they must be stored in a clean area to avoid recontamination.

Risks of extended use and reusable eye protection:

- The removal, storage, re-donning, and reuse of the same, potentially contaminated PPE items without adequate reprocessing is one of the principal sources of risk to health care workers.
- Extended use of goggles, safety glasses, face shields may increase the discomfort and fatigue of health care workers
- Skin tissue damage may occur to face with prolonged use

Removal criteria and precautions:

- Follow the safe procedure for removal of goggles, safety glasses, face shields to prevent contamination of eyes
- Remove, reprocess, and replace if goggles, safety glasses, face shields are contaminated by splash of chemicals, infectious substances, or body fluids
- Remove, reprocess, and replace if goggles, safety glasses, face shields obstruct health care worker safety or visibility of health care environment or become loose

¹¹ <https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/what-we-know>

Face Masks

Given community spread of COVID-19 within Ontario and evidence that transmission may occur from those who have few or no symptoms, masking (surgical/procedure) mask for the full duration of shift for Members and other staff working in direct patient care areas is recommended.

Guiding principles of masks:

- Wearing a mask is only one part of PPE
 - A mask is also worn as part of source control
- Masks alone do not protect all the mucous membranes of the face of the wearer (i.e. the eyes).
- Hand hygiene must be performed before putting on and after removing or otherwise handling masks

Universal Mask Use in Health Care¹²

Universal masking versus personal protective equipment (PPE)

Universal masking means wearing a mask always. Masks used as part of universal masking are used to protect others from the wearer.¹³ Persons wearing a mask must still also ensure physical distancing of at least two metres (six feet) to prevent exposing themselves to droplets from others. Masks are to be discarded if visibly soiled, damp, damaged or difficult to breathe through. After use, masks are to be handled in a manner that minimizes the potential for cross-contamination.

Extended use and re-use of masks:

Under extreme supply limitations, a single mask may be worn for an extended period¹⁴ (i.e. donned at the beginning of the shift, and continued to be worn) as long as it is not visibly soiled, damp, damaged or difficult to breathe through. Masks are to be discarded at the end of the shift/day. The mask is to be donned when entering the facility/home and removed when eating or leaving the facility/home at the end of the shift/day.

Patient Provision of PPE

Clinics are not required to provide surgical masks for patients. However, Members may choose to provide masks for patients. If a Member chooses to provide masks for patients, the Member or staff must educate the patient on the proper donning and doffing of masks and observe that it occurs properly. Infographic Signage is available from PHO and MOH that can be posted in the office.

Patients and essential visitors MUST wear some form of face covering during their visit to Members' facilities.

¹² <https://www.publichealthontario.ca/-/media/documents/ncov/ipac/report-covid-19-universal-mask-use-health-care-settings.pdf?la=en>

¹³ <https://www.publichealthontario.ca/-/media/documents/ncov/ipac/report-covid-19-masking-source-control-workers-non-healthcare-settings.pdf?la=en>

¹⁴ <https://www.publichealthontario.ca/-/media/documents/ncov/ipac/report-covid-19-universal-mask-use-health-care-settings.pdf?la=en>

Patients and essential visitors must be informed of this requirement at the time of procuring an appointment. The mask that the patient wears is NOT required to be a medical/surgical mask. Examples include: homemade masks, scarves, bandanas, etc.

Patients will be asked prior to appointment to enter clinic wearing a facial barrier (homemade mask, bandana, scarf) that covers their mouth and nose for duration of appointment. Patient will also be required to perform hand hygiene (hand sanitizer) upon entry and exit of clinic. Hand sanitizer will be readily available at entrance and exit. If the patient presents with an essential visitor all of the precautions above apply to that individual as well. This information will be communicated to patients at time of booking.

If the patient is unable or refuses to wear a mask it must be considered that the rationale for patient use of face coverings is for the Member's protection, it is well within the rights of the Member to refuse or arrange alternate care of the patient in question.

Clinical Attire

Clean attire must be worn by the practitioner and staff each day. Clinical attire can be an asset to minimize exposure to hazards and prevent illnesses and infection to the worker.

Members and staff are encouraged to change into and out of clinical attire upon entering and leaving the clinical facility. Members and staff involved with direct-patient care should change into different clothes at the end of their shift.

To clean clothes worn in the clinic, wash clothing in hot water (above 60°C) with regular laundry soap.

Health Human Resources (HHR)

Members must ensure adequate staffing to provide services, including ensuring there is adequate PPE for staff members in the health setting based on the organizational risk assessment and application of the hierarchy of controls. Considerations should also be given to preserving HHR capacity where possible as part of planning for future surges/outbreaks.

Minimize staff in the health care setting should be considered. Evaluation of what tasks that can be done from home or outside of regular hours in order to minimize staff interactions with each other and patients.

Members are encouraged to review COVID-19 Operational Requirements: Health Sector Start for more detailed information.

Exclusion or Work Restrictions in the Case of Staff or Member Illness

Staff and Members must self-screen for symptoms before arrival at work with the same symptom screening questions used for patients. If screening is positive, staff and Members must not come to the clinic.

Screening questions for Staff and Members

Refer to Regular Screening Questions as mentioned in document. Check for updates from [Ministry of Health](#), PHO, or COCOO regarding any updates to COVID-19 [case definitions](#) and screening questions.

As per PHO and CMOH, Members and staff who screen positive for the questions above need to refer to [How to Self-Isolate while Working fact sheet](#) and the [Quick Reference Sheet Public Health Guidance on Testing and Clearance](#).

Current requirements from PHO and MOH state that self-isolation must start, and workers must not return to work, until 14 days have passed from symptom onset (or 14 days from positive test collection date if never had symptoms), provided that the individual is afebrile and symptoms are improving. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. It is best practice to contact Public Health and ask for guidance regarding clinic requirements to reopen.

As per the CMOH, Members and staff must also immediately inform their direct supervisor at the onset of any symptoms from the screening questions. Members who become symptomatic while treating patients must stop seeing patients immediately and follow self-isolation procedures. Refer to the PHO “How to Self-Isolate while Working fact sheet” for more information.

This requirement is subject to change and Members are directed to stay up to date with the directives of the CMOH.¹⁵ Members are reminded that employers may also set requirements for return to work, so long as those requirements are not less stringent than those established by the CMOH. For more information regarding testing and clearance, refer to the MOH [Quick Reference Sheet Public Health Guidance on Testing and Clearance](#)

Members and staff who have returned from travel outside of Ontario in the last 14 days and/or have a confirmed, unprotected exposure to a person with COVID-19 may continue to work with specific precautions if they are critical to operations. Refer to [How to Self-Isolate while Working](#)

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http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_clearing_cases_guidance.pdf

[fact sheet](#) and the [Quick Reference Sheet Public Health Guidance on Testing and Clearance](#) available on the MOH COVID-19 website.

All workplaces must develop a workplace illness policy, as per the Government of Ontario's requirements.

Members are required to call their [local Public Health Ontario](#)¹⁶ unit to receive guidance if they are aware of a staff member who has worked within their clinic within the last 14 days and is now testing (or has tested) positive for COVID-19. Also available is Public Health Ontario's Customer Service Centre at 416-235-6556 / 1-877-604-4567.

Resources

General

[Ontario Health COVID-19 Health System Response Materials](#)

[Government of Canada COVID-19 For Health Care Professionals](#)

[MOH Ontario COVID-19 Guidance Essential Workplaces](#)

[PHO COVID-19](#)

[MOHLTC Health Services in Your Community](#)

[MOHLTC COVID-19 Guidance for the Health Sector](#)

[MOH COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#)

Screening

[Ontario Ministry of Health Screening Checklist](#)

¹⁶ <http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx>

[Passive Screening Signage-EN](#)
[Passive Screening Signage-FR](#)

Hand Hygiene

[Health Canada – Authorized list of hard-surface disinfectants and hand sanitizers](#)
[PHO How to Hand rub](#)
[PHO How to Handwash](#)

Environmental cleaning and disinfection

[Health Canada – Authorized list of hard-surface disinfectants and hand sanitizers](#)
[COVID-19 Public Health Ontario Environmental Cleaning](#)
[PHO COVID-19 Cleaning and Disinfection for Public Settings](#)
[PIDAC Best Practices for Environmental Cleaning](#)

Infection Prevention and Control

[PIDAC Routine Practices and Additional Precautions in all Health Care Settings](#)
[PIDAC Best Practices for Hand Hygiene in All Health Care Settings](#)
[PIDAC Infection Prevention and Control for Clinical Office Practice](#)
[PIDAC Best Practices for Prevention, Surveillance and Infection Control Management of Novel Respiratory Infections in All Health Care Settings](#)
[COCOO COVID-19 Administrative and Engineering Controls](#)

Personal Protective Equipment

[Ontario Health PPE Use During the COVID-19 Pandemic](#)
[Ontario Health Optimizing the Supply of Personal Protective Equipment during the COVID-19 Pandemic](#)
[PHO Recommended Steps for Putting On and Taking Off PPE](#)
[PHO “Putting on a Gown and Gloves” and “Taking off a Gown and Gloves” \(videos\)](#)
[PHO “Putting on Mask and Eye Protection” and “Taking off Mask and Eye Protection” \(videos\)](#)
[PHO COVID-19 Droplet and Contact Precautions -Non-Acute Care Facilities](#)

Exclusion or work restrictions during staff or Member illness

[MOH COVID-19 Guidance: Essential Workplaces](#)
[MOH COVID-19 Self-Assessment Tool](#)
[MOH COVID-19 Reference Documents for Symptoms](#)
[Ministry of Labour, Training and Skills Development Workplace Exposure and Illness](#)

Appendix

Appendix A: Regular Screening Questions May 17th, 2020

Q1: Did the person have close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?

Q2: Does the person have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?

Q3: Does the person have any of the following symptoms:

- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose/sneezing without other known cause

Q4: If the person is 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

Appendix B: Directive #2 Principles

Decisions related to the gradual restart of services should be made using fair, inclusive and transparent processes for all patients following the principles articulated in Directive #2 (May 26th, 2020):

- **Proportionality.** Decision to restart services should be proportionate to the real or anticipated capacities to provide those services.
- **Minimizing Harm to Patients.** Decisions should strive to limit harm to patients wherever possible. Activities that have higher implications for morbidity/mortality if delayed too long should be prioritized over those with fewer implications for morbidity/mortality if delayed too long. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering.
- **Equity.** Equity requires that all persons with the same clinical needs should be treated in the same way unless relevant differences exist (e.g., different levels of clinical urgency), and that special attention is paid to actions that might further disadvantage the already disadvantaged or vulnerable.
- **Reciprocity.** Certain patients and patient populations will be particularly burdened as a result of our health system's limited capacity to restart services. Consequently, our health system has a reciprocal obligation to ensure that those who continue to be burdened have their health monitored, receive appropriate care, and be re-evaluated for emergent activities should they require them.

Appendix C: Hierarchy of Hazard Controls

The application of the following hierarchy of hazard controls is a recognized approach to containment of hazards, including health hazards, and is fundamental to occupational health and safety.

1. Elimination and Substitution

Elimination and substitution are considered to be the most effective means in the hierarchy of controls. However, they are often not feasible to implement within all health care settings

- Examples include: not having patients physically come into the office/clinic, telemedicine, etc.

2. Engineering and Systems Control Measures

These measures help reduce the risk of exposure to a pathogen or infected source hazard by implementing methods of isolation or ventilation. These measures work to reduce exposure by isolating the hazard from the worker and by physically distancing actions to reduce the opportunity for transmission.

- Examples include: physical barriers like plexiglass barriers for administrative staff. A plexiglass barrier can protect reception staff from sneezing/coughing patients.

3. Administrative Control Measures

Administrative control measures aim to reduce the risk of transmission of infection to staff and patients through implementing policies, procedures, training, and education with respect to infection prevention and control.

- Examples include: active screening, passive screening (signage), and restricted visitor policies.

4. Personal Protective Equipment (PPE)

PPE controls are the last tier in the hierarchy of hazards controls and should not be relied on as a stand-alone primary prevention program. An employer of an HCP plays a critical role in ensuring staff have access to appropriate PPE for the task to be performed, and the necessary education/training to ensure competency on the appropriate selection, use, maintenance, and disposal of PPE.

- Examples of PPE include: gloves, gowns, facial protection (including surgical/procedure masks and N95 respirators), and/or eye protection (including safety glasses, face shields, goggles, or masks with visor attachments).