This document is a scan of available national and international guidance on isolation and quarantine for consideration when developing public health and/or primary care guidance – **as of April 1st, 2020.** 

Those using the document are welcome to add to this scan as they deem appropriate.

**2) Existing Guidance and Related Documents**

***International Guidance***

**WHO Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected – Interim guidance**<https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125>

* This two-pager provides essential information on achieving the highest level of effectiveness in the response to the COVID-19 including standard procedures to consider. It can serve as baseline guidance to then apply necessary cultural and local considerations.

Ensuring triage, early recognition, and source control:

* Clinical triage includes a system for assessing all patients at arrival to a health facility or triage point, allowing for early recognition of possible COVID-19 and immediate isolation of patients with suspected disease in an area separate from other patients (source control). To facilitate the early identification of cases of suspected COVID-19, health care facilities should:
  + encourage HCWs to have a high level of clinical suspicion;
  + establish a triage station at the entrance to the facility, supported by trained staff;
  + institute the use of screening questionnaires according to the updated case definition (see attached tool). Please refer to the Global Surveillance for human infection with coronavirus disease (COVID-19) for case definitions, and
  + post signs in public areas reminding symptomatic patients to alert HCWs.

Implementing administrative controls:

* Administrative controls and policies for the prevention and control of transmission of COVID-19 within the health care setting include, but may not be limited to: establishing sustainable IPC infrastructures and activities; educating patients’ caregivers; developing policies on the early recognition of acute respiratory infection potentially caused by COVID-19 virus; ensuring access to prompt laboratory testing for identification of the etiologic agent; preventing overcrowding, especially in public areas; providing dedicated waiting areas for symptomatic patients; appropriately isolating patients; ensuring adequate supplies of PPE; and ensuring adherence to IPC policies and procedures for all aspects of health care.

Recommendation for outpatient care:

* The basic principles of IPC and standard precautions should be applied in all health care facilities, including outpatient care and primary care. For COVID-19, the following measures should be adopted:
  + triage and early recognition;
  + emphasis on hand hygiene, respiratory hygiene, and medical masks to be used by patients with respiratory symptoms;
  + appropriate use of contact and droplet precautions for all suspected cases;
  + prioritization of care of symptomatic patients;
  + when symptomatic patients are required to wait, ensure they have a separate waiting area;
  + educate patients and families about the early recognition of symptoms, basic precautions to be used, and which health care facility they should go to.

**Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19)**

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control>

If a decision to implement quarantine is taken, the authorities sh**Available National/International Guidance on Isolation/Quarantine - COVID-19 0 April1, 2020**

**1) Purpose:**

ould ensure that:

* the quarantine setting is appropriate and that adequate food, water, and hygiene provisions can be made for the quarantine period;
* minimum IPC measures can be implemented;
* minimum requirements for monitoring the health of quarantined persons can be met during the quarantine period.

**Q&A on infection prevention and control for health care professionals caring for patients with suspected or confirmed 2019-nCoV**

<https://www.who.int/news-room/q-a-detail/q-a-on-infection-prevention-and-control-for-health-care-workers-caring-for-patients-with-suspected-or-confirmed-2019-ncov>

* Are there special procedures for the management of bodies of persons who have died from 2019-nCoV?
  + No, there are no special procedures for the management of bodies of persons who have died from 2019-nCoV. Authorities and medical facilities should proceed with their existing policies and regulations that guide post-mortem management of persons who died from infectious diseases.
* Can chlorine solutions also be used?
  + Chlorine solutions are strongly discouraged as they carry a higher risk of hand irritation and ill health effects from making and diluting chlorine solutions, including eye irritation and respiratory problems. In addition, there is a risk of loss of antimicrobial effect if exposed to sunlight or heat. Preparing chlorine solutions requires training to reach the correct dose of 0.05% with varying strengths of bleach available in the private sector. Even if stored at a cool dry place with a lid away from sunlight, they have to be renewed daily. In comparison simple soapy water solution do not have any of the above-mentioned health risks and complications including loss of antiviral effect due to heat or sunlight. The antiviral effect of soapy water is due to the oily surface membrane of the COVID-virus that is dissolved by soap, killing the virus.
* Isolation ward model
  + A model for setting up an isolation ward is currently under development. PPE specifications for healthcare professionals caring for nCoV patients can be found  in the disease commodity package at: <https://www.who.int/publications-detail/disease-commodity-package---novel-coronavirus-(ncov)>

**Alternate Care Site Tool Kit – United States, Federal Health Care Resilience Task Force**

[**https://files.asprtracie.hhs.gov/documents/acs-toolkit-ed1-20200330-1022.pdf**](https://files.asprtracie.hhs.gov/documents/acs-toolkit-ed1-20200330-1022.pdf)

Developed for state, local, tribal and territorial (SLTT) entities

Use - to address potential shortages in medical facilities during the 2020 COVID-19 pandemic; care provided in an non-traditional environment

Two levels of care

* General
* Acute

Information provided on physical structure, types of services, patient care considerations,

Includes procedures on:

* How to undertake a site assessment
* Operate a site
* Site flow plan
* Site security
* Site communications

**MSF - Practical manual to set up and manage a SARI treatment centre and a SARI screening facility in health care facilities (start at page 37, includes a sample lay out):**

<https://apps.who.int/iris/bitstream/handle/10665/331603/WHO-2019-nCoV-SARI_treatment_center-2020.1-eng.pdf?sequence=1&isAllowed=y>

At MSF we have an similar but brief internal document for setting up Covid screening and treatment facilities in tents (similar in size to the BluMed structures). We are awaiting approval to share this externally. Here in Canada we are working on turning this practical set up instructions into training modules that could support remote communities in Canada. We will be in touch as these materials become available.

**Advice on the use of point-of-care immunodiagnostic tests for COVID-19 (April 8, 2020):**

<https://apps.who.int/iris/bitstream/handle/10665/331713/WHO-2019-nCoV-Sci_Brief-POC_immunodiagnostics-2020.1-eng.pdf?sequence=1&isAllowed=y>

**US Center for Disease Control: Appendix D3: Guidelines for Evaluating Homes and Facilities for Isolation and Quarantine, Supplement D: Community Containment Measures, Including Non-Hospital Isolation and Quarantine, Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)**

<https://www.cdc.gov/sars/guidance/d-quarantine/app3.html>

When persons requiring isolation or quarantine cannot be accommodated either at home or in a healthcare facility, a community-based facility may be used.

Is the facility criteria outlined for both isolation and quarantine? ***No***

*Home quarantine*: A person’s residence is generally the preferred setting for quarantine. Points to be considered in the evaluation include:

* Availability of/access to educational materials about SARS and quarantine
* Basic utilities (water, electricity, garbage collection, and heating or air-conditioning as appropriate)
* Basic supplies (clothing, food, hand-hygiene supplies, laundry services)
* Mechanism for addressing special needs (e.g., filling prescriptions)
* Mechanism for communication, including telephone (for monitoring by health staff, reporting of symptoms, gaining access to support services, and communicating with family)
* Accessibility to healthcare professionals or ambulance personnel
* Access to food and food preparation
* Access to supplies such as thermometers, fever logs, phone numbers for reporting symptoms or accessing services, and emergency numbers (these can be supplied by health authorities if necessary)
* Access to mental health and other psychological support services

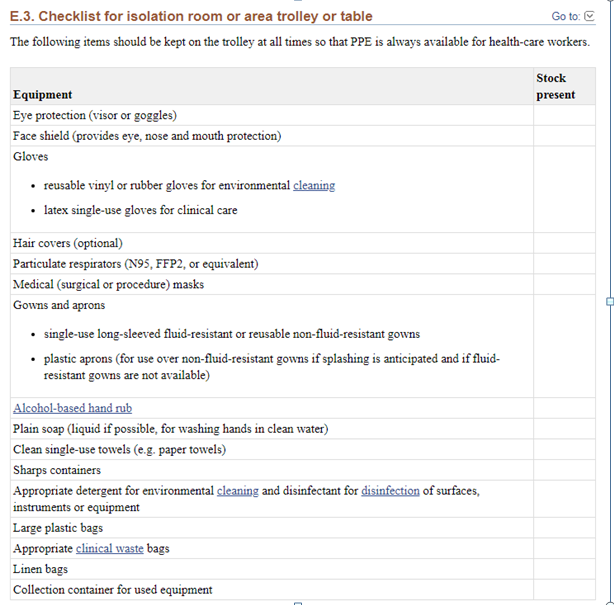
*Community-based facility quarantine*: Additional considerations, beyond those listed for home quarantine, include:

* Separate rooms and bathrooms for each contact
* Delivery systems for food and other needs
* Staff to monitor contacts at least daily for fever and respiratory symptoms
* Transportation for medical evaluation for person who develop symptoms
* Mechanisms for communication, including telephone (for monitoring by health staff, reporting of symptoms, gaining access to support services, and communicating with family)
* Services for removal of waste. (Note: No special precautions for removal of waste are required as long as persons remain asymptomatic)

**The National Center for Biotechnology Information -** **Infection Prevention and Control of Epidemic- and Pandemic-Prone Acute Respiratory Infections in Health Care**<https://www.ncbi.nlm.nih.gov/books/NBK214341/?fbclid=IwAR37bnsreDpClDiBM6gt_jMf3PwvKsKTVoRNEU4MW5plhVsRec4IyPJmpm8>

Annex E: Isolated Rooms or Areas - Preparation of the isolation room or area:

* Ensure that appropriate handwashing facilities and hand-hygiene supplies are available
* Stock the sink area with suitable supplies for handwashing, and with alcohol-based hand rub, near the point of care and the room door.
* Ensure adequate room ventilation.
* Post signs on the door indicating that the space is an isolation area.
* Ensure that visitors consult the  person responsible for keeping a visitor record before being allowed into the isolation areas. Keep a roster of all staff working in the isolation areas, for possible outbreak investigation and contact tracing.
* Remove all non-essential furniture and ensure that the remaining furniture is easy to clean, and does not conceal or retain dirt or moisture within or around it.
* Stock the PPE supply and linen outside the isolation room or area (e.g. in the change room). Setup a trolley outside the door to hold PPE. A checklist may be useful to ensure that all equipment is available. Poster on appropriate use of PPE should be available. (check-list below)
* Place appropriate waste bags in a bin. If possible, use a touch-free bin. Ensure that used (i.e. dirty) bins remain inside the isolation rooms.
* Place a puncture-proof container for sharps disposal inside the isolation room or area.
* Keep the patient's personal belongings to a minimum. Keep water pitchers and cups, tissue wipes, and all items necessary for attending to personal hygiene, within the patient's reach.
* Dedicate non-critical patient-care equipment (e.g. stethoscope, thermometer, blood pressure cuff and sphygmomanometer) to the patient, if possible. Thoroughly clean and disinfect patient-care equipment that is required for use by other patients before use.
* Place an appropriate container with a lid outside the door for equipment that requires disinfection or sterilization.
* Keep adequate equipment required for cleaning or disinfection inside the isolation room or area, and ensure scrupulous daily cleaning of the isolation room or area.
* Set up a telephone or other method of communication in the isolation room or area to enable patients, family members or visitors to communicate with health-care professionals. This may reduce the number of times the professionals need to don PPE to enter the room or area.



**Ebola Treatment Unit (ETU) - CDC**  
<https://www.cdc.gov/vhf/ebola/hcp/safety-training-course/assets/E-Lecture_ETU.pdf>

* Ensure you have community acceptance
* Avoid the term “isolation unit” and use a term with a more positive connotation such as treatment unit
* Messaging should stress facilities provide good supportive care, such as medicine and nutritious food
* Keep unit clean and comfortable
* Maintain transparency (use low or mesh fences) and have visitor access areas outside, but close enough to patient quarters so visitors can talk to patients through these fences (visitors become especially important for patient morale)

***Domestic Guidance***

**Ottawa Treatment and Isolation Centre**  
<https://nationalpost.com/pmn/news-pmn/canada-news-pmn/ottawa-opens-covid-19-isolation-and-treatment-centre-for-homeless>

* Offer assessments by nurse practitioners and mental health professionals, as well as 24-7 health services
* Include expertise from individuals who manage alcohol and opiates programs, so people with addictions are less likely to leave the centre before their isolation is through

**Kingston Self Isolation Centre**  
<https://www.cityofkingston.ca/-/a-kingston-self-isolation-centre-readies-to-receive-referrals-from-the-covid-19-assessment-centre>

* Accepts referrals from the COVID-19 Assessment Centre to provide an appropriate space for individuals experiencing homelessness to reside during their self-isolation or quarantine period
* Implement an emergency department diversion strategy that provides safe and appropriate supports for individuals who would not otherwise have access to a space to self-isolate or be quarantined (managed by addiction and mental health services)

*\*\*When needed, existing buildings can be re-purposed as isolation centres/shelters for those community members who may be unable to self-isolate at home for various reasons. Examples of areas that can be re-purposed include, but are not limited to, university residences, train cars, mobile homes, community centers, schools, churches, hotels, etc.*

**Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings**

<https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections/part-b.html#B>

This document provides an in-depth explanation of routine infection control and prevention practices and additional precautions in limited exceptional cases. There are no COVID-19 specifics. Standard information on:

* The role of healthcare professionals
* Risk assessments, hygiene, and source control (triage, diagnosis, etc.)
* Patient placement and accommodation (limited to healthcare setting)
* Patient flow
* Aseptic technique
* Use of PPE
* Environmental cleaning
* Handling of deceased bodied
* Education of patients, families, and visitors
* Visitor management

Isolation-related information:

* Appropriate number and location of airborne infection isolation rooms (including critical care units, inpatient units, dialysis units, emergency departments and ambulatory care clinics), according to the organizational risk assessment.
* Ventilation systems should be maintained and operated as per the ventilation system's manufacturer and in accordance with current publications, including, but not limited to, a monitoring schedule for airborne infection isolation rooms (e.g., air changes per hour, pressure differentials and filtration efficiencies) and establishing an action plan to review and, where necessary, upgrade the ventilation systems of facilities to meet specifications
* Airborne infection isolation rooms, bronchoscopy suites and rooms used for sputum induction should be designed and maintained according to the most current infection prevention and control specifications
* Washrooms connected to an airborne infection isolation room should be exhausted using the same exhaust system as the room itself.
* Policies and practices that result in stigmatization of patients with antibiotic-resistant microorganisms (e.g., disease-specific signage) or increase the patient's sense of isolation should be avoided. Recognizing that patients on contact precautions may have fewer contacts with healthcare providers and that this may reduce their quality of care, steps should be taken to mitigate this impact on care.

**3) Limitations of existing literature/Additional Considerations:**

In the current COVID-19 guidance on isolation and quarantine, there is limited or no reference to important cultural and community considerations for Inuit, First Nations and Métis including:

* Risk perception
* Past and persisting traumas (ie. Forced removal, TB, Indian hospitals, etc.)
* High numbers of persons with disabilities and chronic care needs
* Cultural continuity in isolation and quarantine (i.e. traditional medicines, community care, etc.)
* Persons with disabilities & complex care needs
* Mental health status
* Access to housing
* Violence and safety (ie. Domestic, gender-based, children, and seniors)
* Remoteness

**Lessons learned from the Gathering for Health and Cultural Safety during Evacuations – Summary & Final Report**

Potential impacts for First Nations people if required to isolate away from their home:

* Trauma incurred during the entire isolation process
* Racism faced while at Isolation Centres
* Potential food insecurity upon return to the home due to loss of animals and berries, etc.
* Theft of personal items and property damage while in isolation
* Anxiety / worry and concern for pets left behind

Ensure the following:

* Mental health supports are available during isolation (with access to wellbeing and wellness checks for isolated community members)
* Provide access to traditional diets
* Provide access to programming (social & cultural) or recreation activities (while adhering to isolation requirements)
* Provide clear and timely information around procedures.
* Clear and ongoing communication between community members in isolation and their leadership, health care providers, PT leadership, etc…
* If feasible, put isolation centres/shelters directly in First Nations communities
* Use a collaborative approach to addressing medical needs, that include Traditional and Western approaches
* Provide information to community about the isolation shelters/centres in order to help prepare

Tools, supports, and practices required to ensure a “culturally safe environment” for First Nations communities that experience COVID-19 Isolation:

* Service providers to use the Mental Wellness Continuum as a guiding framework for informing isolation processes
* More resources and support for communities to develop COVID-19 Isolation Response Plans
* Consideration of family systems and traditions when designing isolation protocols, as they differ from mainstream Canadian society
* Cultural competency training for health care providers and front-line staff
* Better access to ongoing mental health supports
* More kindness and consideration from service providers
* Opportunities for community members in isolation to provide input to service providers on how needs can be addressed in a culturally appropriate manner.

**4) Recommendation**

Provide additional isolation and quarantine guidance with cultural considerations from additional literature to build on current Federal and WHO guidelines. This can include easy-to-read guidance for communities and partners, as well as tools/checklists for assessing the effectiveness and appropriateness of an isolation/quarantine center or procedure.