COVID-19 Guidance:
Alternate Health Facilities

Ministry of Health

COVID-19 Guidance: Alternate Health Facilities

Version 1 – April 6, 2020

This guidance document provides basic information only. It is not intended to take the place of medical advice, diagnosis, or treatment.

- Please check the Ministry of Health (MOH or Ministry) COVID-19 website regularly for updates to this document, case definition, FAQs, and other information: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx

Definition

Alternate Health Facilities (AHFs) may be established by hospitals in non-traditional settings to provide additional capacity for care. They may expand in-patient and/or out-patient capacity. AHFs may occupy existing structures such as schools, dormitories, arenas, conference centres, or vacant nursing/retirement homes, or may create temporary facilities (also known as 'field hospitals'), using tents or other portable structures.

Purpose/Context

- The purpose of this document is to provide guidance and offer suggestions to hospitals for establishing alternate health facilities (AHFs) should the need arise for additional patient care capacity.
- AHFs may be established to:
    - Shift less acute non-COVID-19 patients (i.e., free from COVID-19, but with other care needs) out of the hospital main site, to create greater capacity for patients with COVID-19 (e.g., the critically ill).
    - Extend hospital services for patients with COVID-19 no longer requiring hospital care, e.g., for the care of patients who are not critically ill, as domiciliary care for those who are unable to care for and/or isolate

themselves at home, or as "step-down" units for the care of stable patients transferred from acute care hospitals.
    - Provide ambulatory care services to free up ambulatory care space in the hospital main site.
    - Isolate and treat patients with COVID-19.
- Such facilities should only provide care to one of these patient populations and, as much as possible, staff should be dedicated to one population or the other (COVID or non-COVID) to guard against cross-transmittal of novel coronavirus infection.
- It is understood that some of these facilities will have limitations, which may preclude meeting all the requirements that would normally be expected of a hospital facility. Given the urgency of the COVID-19 situation, hospitals have discretion over the facilities chosen.
- Despite this discretion, under the *Occupational Health and Safety Act* (OHSA), employers have a responsibility to protect worker health and safety in the workplace, including AHFs.
- As per the March 26, 2020 memo from the Assistant Deputy Minister, Hospitals and Capital Division, MOH, (ADM memo) the Ministry is waiving the submission requirements set out under the Section 4 Approvals Protocol relating to approval requests under subsection 4(2) of the *Public Hospitals Act*, (PHA).
- In the ADM memo, general approval was granted to all public hospitals under subsection 4(2) of the PHA to operate and use an institution, building or other premises or place ("premises") for the purposes of a hospital until June 30, 2020 unless it is revoked earlier, provided that the following conditions are met:
    - The hospital is leasing, licensing or otherwise acquiring a temporary right to occupy the premises after **March 26, 2020** to address the hospital's need to create greater capacity for the treatment of patients arising from the COVID-19 virus;
    - The term of any lease entered into does not exceed **June 30, 2020**;
    - The premises are selected with due regard to their suitability for the intended purpose (in view of current exigencies and system challenges) and for the safety of patients, hospital staff and others;
    - The hospital agrees to provide to the Ministry as soon as reasonably practicable any information that the Ministry may request relating to the premises including, without limitation, the address, specific premises or portions of premises that are being occupied (e.g., floor(s),

unit(s)), purposes for which the premises are being used, number of beds being operated on the premises, details respecting rents, copy of lease or licence agreement, etc.
    - If alternate health facilities are used for beds, beds must be registered within the MOH's daily bed census tool.
- Additional guidance has been developed for hospitals wishing to use hotels as temporary housing for healthcare workers or patient care for low acuity ALC patients.
- This document is intended to provide general guidance on organizational processes (such as patient flow and infection prevention and control), infrastructure and professional and support service considerations, rather than medical, nursing and other health staffing levels or specific COVID-19 clinical guidelines.

Planning Considerations

Role of Ontario Health and Hospitals

Ontario Health (OH) as the operator of the system has been designated the primary responsibility for patient care capacity. This has been operationalized through two key structures: A Critical Care Table; and five Ontario Regional Tables, working in close partnership with their local health care leadership. The five OH regional capacity planning tables are designed to ensure local hospitals, long term care, etc., are planning collectively for added capacity and working to ensure necessary growth in capacity while managing stakeholder expectations and communication in a standardized manner.

Hospitals are encouraged to work with their Ontario Health regional planning table in planning AHFs, according to regional capacity needs.

Should hospitals, with OH input, open an alternate health facility with inpatient beds, they must register and report those beds through the Ministry of Health's daily bed census reporting instrument.

Hospitals may track these expenses as COVID-19 related and work with Ontario Health and the Ministry of Health on future reimbursement.

Using Other Organizations for Assistance

Hospitals seeking to construct AHFs with other governmental or non-governmental partners such as Ontario's Emergency Medical Assistance Team, the Canadian Red Cross/other NGOs, or private suppliers, should first discuss such strategies with their OH regional planning table, in order to optimize and prioritize such requests. Requests for Federal Government resources such as the Canadian Armed Forces (CAF) support should be considered only as a last resort and will require intergovernmental approval between Ontario and the federal government.

Infrastructure Ontario Support

Infrastructure Ontario (IO) has offered their project management and contract services expertise to hospitals to activate alternate health facilities should their assistance be required. You will find their contact information and available services in **Appendix A**.

AHF Planning Elements

Hospitals may consider the following elements in planning their AHFs.

1. **Site planning**
    - As per the ADM memo, the premises will be selected with due regard to their suitability for the intended purpose (in view of current exigencies and system challenges) and for the safety of patients, hospital staff and others.
    - In addition to consultation with their OH Regional Table, hospitals can seek support from Infrastructure Ontario, in such areas as selecting and securing sites, as outlined in Appendix A.
    - Planning should include steps taken to meet the requirements of the OHSA and its regulations.
    - Planning may need to include an assessment of the adequacy of the power supply, including emergency backup generators and compliance with Ontario Regulation 164/99: Electrical Safety Code under the *Electricity Act*, as well as ventilation, water supply and washroom facilities. The AHF should consult with the Electrical Safety Authority to ensure compliance with its revised standards for temporary emergency health care facilities. Hydro One support is also available to ensure reliable power supply to AHFs in conjunction with local utilities.
    - Other considerations may include need for permits, access to facilities (e.g., parking and public transit), internal space/layout, and ease of making

arrangements to support the provision of clinical care (security, maintenance, housekeeping, food service, laundry, equipment and supply reprocessing, separate receiving area for supplies, need for shuttle service to/from main hospital site for transportation of staff/patients/laboratory specimens, access to Emergency Medical Services, etc.).

2. Administrative and management planning

An individual or team may be designated to oversee the care provided in each AHF and should determine the need for 24/7 on-site management.

Management responsibilities could include:

- Human resources – staffing, payroll
- Service management – patient care protocols/staff guidance, monitoring of patient flow, maintaining situational awareness
- Liaison with local public health unit, as needed
- Securing appropriate insurance
- Community partnerships (e.g., mental health services)
- Fire safety/disaster plan; Code Blue response

3. Other Planning Elements

Appendix B provides advice related to planning for care of COVID-19 and/or non-COVID-19 AHFs, under each of the following categories:

- Infrastructure Planning
- Professional Service Planning
- Support Service Planning
- Supply Planning

4. COVID-19 Care Considerations

Appendix C provides details specific to COVID-19 care processes in alignment with directives, guidance and best practices from the Ministry, Public Health Ontario and other sources. Information is provided on the following:

- Patient Flow
- Personal Protective Equipment and Other Precautions
- Screening
- Occupational Health and Safety
- Cleaning, Disinfection and Waste Management

5. Frequently Asked Questions

Appendix D provides answers to questions hospitals may have related to planning and implementation of AHFs.

Appendix A: Infrastructure Ontario Supports

Area of support	Description of services in support of hospital needs
Selecting and securing sites	▪ **Inventory of suitable land/buildings** – prioritizing adjacent / close to hospital sites (i.e., both public and private sector assets) ▪ Direct **use of other public sector land** where suitable and available ▪ **Short-term lease negotiation and execution** of private land/buildings where required ▪ **Supporting / expediting necessary permitting** and approvals
Design and construction of alternate health facilities (AHF)	▪ **Secure and manage design and construction resources** to build temporary AHFs on hospital grounds ▪ **Connection to required utilities** via hospital site, municipal services or temporary 'off-grid' services ▪ **Compliance** with of fire and life-safety and necessary legislation/regulations
Retrofit / renovation of existing facilities	▪ **Modify adjacent / near-by buildings** with permission of owner, or **fit out/modify existing hospital space** to create additional capacity (e.g., lobby, cafeteria, administration space, etc.)
Management / oversite of costs and risks	▪ Tracking and **oversight of costs** associated with leases, design and construction of AHFs ▪ **Support issue resolution** related to construction, permitting and approvals ▪ **Reporting** to hospitals, MOH and OH as required ▪ Coordination with Emergency Management Ontario and other agencies as required

Key Contact information:

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Appendix B: Other Planning Elements

Hospitals may consider the need for the following for their AHFs:

1. Infrastructure Planning

Infrastructure which may be required includes:

- Temporary structures, including tents and modular facilities (e.g., wards, intensive care)
- Electricity, lighting
- Water supply (sink, shower, pantry/kitchenette, utility sink)
- Heating, ventilation and air conditioning
- Data connections, communications services
- Sanitation (sewage, garbage, recycling, sharps disposal)
- Office space
- Patient rooms/dormitories (with privacy screen/curtains)
- Clean and soiled utility rooms

2. Professional Service Planning

While hospitals will determine the activities and skills required at their facilities, professional staff may be required including:

- Physician and/or Nurse Practitioner
- Nursing staff (Registered Nurse, Registered Practical Nurse, Personal Support Worker)
- Rehabilitation: Physiotherapy, occupational therapy
- Respiratory therapy
- Discharge planner (e.g., social worker)
- Pastoral care/counsellor

3. Support Service Planning

Support services which may be required include:

- Transportation services (e.g., golf carts/shuttle service for staff, patients, laboratory specimens, etc.; private transportation services (including stretcher transportation services))
- Security
- Clerical and reception staff
- Patient education staff
- Housekeeping and linen services

- Maintenance services (electrical, plumbing)
- Morgue services
- Food services
- Storage and delivery of medical supplies and equipment
- Cleaning, autoclaving and disinfection of reusable supplies/equipment
- Access to laboratory services, radiology
- Health records management
- Pharmacy services
- Information technology supports

4. Supply Planning

Categories of supplies and equipment which may be required include (with suggested examples):

- Medication (over the counter, stock)
- Medical supplies (dressing supplies, intravenous fluid and supplies)
- Personal protective equipment (e.g., masks, gloves, gown, face shield)
- Medical equipment (blood pressure cuff, stethoscope, thermometer, pulse oximeter, suctioning)
- Transportation equipment (gurney, wheelchair)
- Medical gases (portable oxygen)
- Waste management equipment and supplies (urinals, bedpans, washer/disinfector, biohazard (sharps) disposal)
- Post-mortem supplies (shroud, body bag)
- Environmental cleaning and disinfection supplies, including alcohol-based hand rub placed at entrances, elevators, in waiting areas, etc.
- Crash cart (e.g., defibrillator, airway supplies, emergency drugs, personal protective equipment)
- Furnishings (beds/cots, privacy screen/curtains, bedside tables, office furniture, carts for medication/supplies/linen, commode chairs)
- Computers and phones
- Refrigeration (separate units for items including specimens, medication, dietary).

Appendix C: COVID-19 Care Considerations

The following sections provide details on requirements related to care of patients in AHFs with COVID-19. They are intended to provide advice related to care of COVID-19 patients, specifically those who are well enough to be cared for outside of the main hospital setting (e.g., do not require negative-pressure isolation or critical care), to preserve those services for those most in need.

1. Patient Flow

Hospitals should have a plan for how their main site(s) will extend to AHFs, including processes for assessment, transfers, admission, communications, etc. and whether and how patient referrals may be received from community health partners. Hospitals should coordinate with their Ontario Health regional planning table to optimize regional capacity.

Depending on the nature of the services to be provided by the AHF, patients can either be confirmed as positive for COVID-19 upon arrival or considered potentially ill with COVID-19. Procedures should assume that all patients in AHFs are infected with COVID-19 unless or until confirmed otherwise.

Entry Point/Admissions

The following processes may facilitate safe patient flow from the entry point to the AHF, including advice for infection prevention and control:

- If COVID-19 assessments take place on-site, attention to spacing (at least two metres) will be required, given the potential for mixing of patients with and without COVID-19. Separate waiting areas may also be considered for those with symptoms and those without, prior to assessment.
- Signage should be posted to direct and maintain one-way patient flow.
- Ability to accommodate visitors should be considered on a case-by-case basis.
- Staff receiving patients at the entry point should not have direct contact; the patient should wear a surgical mask and keep a distance of at least one metre, unless staff are also wearing surgical masks. Reception staff should ideally be behind a barrier to protect from contact and droplet spread. A Plexiglas barrier can protect reception staff from sneezing or coughing patients, as well as to maintain distance and avoid direct contact.

- Staff should provide routine care or obtain specimens from patients with suspect or confirmed COVID-19 using contact and droplet precautions. These precautions include wearing the following personal protective equipment (PPE) - gloves, gown, surgical/procedure masks and eye protection (goggles, face shields) for routine care. (See Personal Protective Equipment and Precautions section below for further details.)
- Encourage the patient to use respiratory hygiene/cough etiquette, and provide surgical/procedural masks, tissues, alcohol-based hand rub and a waste receptacle.
- An **advanced first aid/transfer area** may be necessary for patients who arrive in distress, and who may require oxygen, suctioning, etc., prior to transfer to hospital main site ER.
- Be aware that confirmed or suspected cases of COVID-19 should be **isolated** (in a room with door closed), or at least separated, from other patients. If possible, dedicated toilet facilities should be made available for confirmed/suspected cases.
- Avoid contact between confirmed/suspected cases and other persons other than direct care staff.
- Admitted patients should be moved out of waiting area to a separate area or patient room as soon as possible.
- If assessments are being performed on-site, a separate exit should be provided for patients who have been assessed but are not being admitted, to ensure one-way patient flow.

In-Patient Care Accommodation

- Confirmed or suspected cases requiring admission should be admitted to a single room with a dedicated bathroom, if available.
- If single rooms are unavailable, maintain a spatial separation of at least two metres between the patient and others in the room and draw the privacy curtain or place other barrier between beds, if available.
- Facilities should consider cohorting confirmed patients with COVID-19 to help prevent further transmission and to help conserve the use of PPE.

Discharge

- Prior to discharge, provide patients with clear instructions for follow-up.
- Hospitalized patients can be discharged from isolation once they meet the criteria for a resolved case (two negative tests at least 24 hours apart). If

discharged home within 14 days of symptom onset, patients should be instructed to follow advice for home isolation (i.e., continue home isolation for 14 days from date of symptom onset).
- Discharge coordination and linking with community supports would be performed by a dedicated staff member (e.g., social worker).

2. Personal Protective Equipment and Other Precautions

- On March 30, 2020 the Chief Medical Officer of Health released a revised directive (Directive #1)[*] requiring the following precautions for health care providers and health care entities working with patients with COVID-19:
    - A point-of-care risk assessment (PCRA) must be performed by every health care worker before every patient interaction.
    - At a minimum, contact and droplet precautions must be used by workers for all interactions with suspected, presumed or confirmed COVID-19 patients. Contact and droplet precautions includes gloves, face shields or goggles, gowns, and surgical/procedure masks, and
    - Contact, droplet and airborne precautions should be used when aerosol generating medical procedures (AGMP)[†] are planned or anticipated to be performed on patients with suspected or confirmed COVID-19, based on a PCRA and clinical and professional judgement. These precautions include wearing the following PPE – gloves, long-sleeved gown, well-fitted, seal-checked N95 fit tested respirators and eye protection (goggles/face shields).
- In acute care settings, airborne infection isolation rooms (AIIR) should be used, if available, for AGMP. Negative pressure should be validated daily. Should an AIIR not be available, a single room may be used with the door closed.
- Further revised direction for hospitals (Directive #5)[‡] was released on March 30, 2020, including the following:

[*] COVID-19 Directive #1 for Health Care Providers and Health Care Entities.

[†] AGMPs include: endotracheal intubation (including during cardio-pulmonary resuscitation), cardio-pulmonary resuscitation (CPR) with airway management (chest compressions alone are not considered to be AGMP), open airway suctioning, bronchoscopy (diagnostic or therapeutic), surgery and autopsy, sputum induction (diagnostic or therapeutic), non-invasive positive pressure ventilation for acute respiratory failure (CPAP, BiPAP3-5), and high flow oxygen therapy.

[‡] COVID-19 Directive #5 for Hospitals within the meaning of the Public Hospitals Act; Issued under Section 77.7 of the Health Protection and Promotion Act, 1990, c. H.7.

    - If a worker determines, based on the PCRA, and based on their professional and clinical judgement, that health and safety measures may be required in the delivery of care to the patient, then the public hospital must provide that worker with access to the appropriate health and safety control measures, including an N95 respirator. The hospital will not unreasonably deny access to the appropriate PPE.
    - The hospital's Organizational Risk Assessment must be continuously updated to ensure that it assesses the appropriate health and safety control measures to mitigate the transmission of infections, including engineering, administrative and PPE measures.
- Please refer to all issued COVID-19 directives for full details and requirements.
- More information about appropriate PPE and other precautions for suspected and confirmed cases of COVID-19 can be found here: https://www.publichealthontario.ca/-/media/documents/ncov/updated-ipac-measures-covid-19.pdf?la=en.

Staff

- In order to maximize the use of PPE in the event of shortages, it is acceptable for staff to wear the same mask or respirator while caring for multiple patients with the same diagnosis without removing the respirator if the mask or respirator is not damaged, soiled or contaminated. This reduces consumption of PPE.
- AGMP have been linked to an increased risk of transmission of coronaviruses and require protection measures. If there is a shortage of respirators, it is recommended that they are primarily reserved for AGMP, with due consideration to the Directives noted above. AGMP should be performed in a negative pressure isolation room if available. The number of persons in the room should be limited to a minimum during such procedures; all persons present should observe contact, droplet and airborne precautions, including PPE as noted above.
- Surgical or procedure masks (as well as gown, glove and eye protection) are used for contact and droplet precautions, in providing direct care to patients with suspected or confirmed COVID-19, including nasopharyngeal and oropharyngeal swab collection.
- Healthcare workers should strictly follow the procedures for the putting on (donning) and the safe removal (doffing) of PPE in correct sequence and with appropriate hand hygiene in between steps. Assistance during donning and

observations of doffing may minimize the risk of accidental contamination. For further information, please see: https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ppe-recommended-steps.pdf?la=en

- Hand hygiene should be performed immediately after removing PPE.
- It is essential to ensure that all staff assigned to treat patients with COVID-19 are trained in the proper use of PPE. Quality assurance should be promoted through appropriate systems before assigning staff to COVID-19 patient care; for example, hospitals could require documented participation in a training course to ensure a staff member's competency in the correct use of PPE.
- The use of dedicated or, if possible, disposable medical equipment (e.g., blood pressure cuffs, stethoscopes and thermometers) is strongly recommended. All reusable equipment should be cleaned and disinfected before using on another patient.
- Administrative areas and administrative tasks that do not involve contact with a patient with suspected or confirmed COVID-19 do not require the use of PPE if appropriate distancing can be maintained or physical barriers are available.

Visitors

- All visitation should be restricted for patients with COVID-19. On a case-by-case basis, exceptions may be considered for compassionate reasons. Visitors would wear the same PPE as recommended for the health care worker and follow the same hand hygiene recommendations. If visitors keep at least two metres away from a patient for the duration of the visit, and PPE availability is very limited, a surgical mask alone may be worn, and meticulous hand hygiene should be performed.
- Visitors should be directed regarding procedures for donning and doffing of PPE as well as how and when to dispose it following use.
- Physical contact between visitors and patients should be strongly discouraged.
- A register of visitors should be maintained for the purposes of contact tracing.
- Visitors of a patient with COVID-19 should self-monitor for symptoms of COVID-19 for 14 days after the visit.

3. Screening

- The latest case definition for screening is available on the MOH COVID-19 website.
- All AHFs should undertake active and passive screening of all individuals entering the facility.
- Signage should be posted on all entry points at AHF sites. Signage should prompt anyone to self-identify to a specific location/person if they screen positive using the case definition.

Active Screening for Staff

- AHF sites must instruct all staff, students and volunteers to self-monitor for COVID-19 symptoms. All staff should be aware of early signs and symptoms of COVID-19 (such as fever, cough or shortness of breath, and other potential symptoms such as sore throat, headache, muscle aches and diarrhea).
- Anyone with symptoms of an acute respiratory infection must not come to work and must report their symptoms to a designated person at the AHF site.
- All staff who are required to self-isolate should not come to work for 14 days after exposure or travel.
    - Staff who have tested positive for COVID-19 and who are critical to operations may return to work under 'work self-isolation' 24 hours after symptom resolution and while awaiting viral clearance to be fully cleared. Testing for viral clearance can commence once symptoms have resolved.
    - Symptomatic staff who test negative can return to work as per usual workplace policies (e.g., shorter of five days from symptom onset or 24 hours after symptom resolution) and continue to self-monitor for the duration of the outbreak.
    - Please see the following for further details on self-isolation: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_clearing_cases_guidance.pdf and https://www.publichealthontario.ca/-/media/documents/ncov/factsheet-covid-19-how-to-self-isolate.pdf?la=en
- All staff who have been advised to self-monitor for 14 days from the date of an exposure should discuss with their supervisor whether to come to work.

Reporting of Positive Screening

- COVID-19 is a designated disease of public health significance (O. Reg. 135/18) and thus reportable to local public health units under the *Health Protection and Promotion Act*.
- The hospital should contact the local public health unit to report a suspect or confirmed case of COVID-19. If the suspect case has been tested, with results pending and the person does not require hospital admission, please notify/consult with the hospital infection prevention and control department and the local public health unit prior to discharge. Laboratory results will be communicated through routine processes for reportable diseases in Ontario which include the local public health unit and the ordering physician.

4. Occupational Health & Safety

- If COVID-19 is suspected or diagnosed in a staff member, return to work should be determined in consultation with their health care provider and the local public health unit. The staff member should report to the hospital's Occupational Health and Safety department (or alternate) prior to returning to work. Detailed general occupational health and safety guidelines for COVID-19 are available on the MOH COVID-19 website.
- Staff providing care to COVID-19 patients need to be actively followed-up with for development of symptoms and provided with occupational health support. AHFs should maintain a record of all staff providing care for confirmed COVID-19 cases.
- AHFs should consult their local public health unit to determine management of staff who may have been exposed to COVID-19 (e.g., close contact of a case without appropriate PPE).
- Client-contact surfaces (i.e., areas within two metres of the person who has screened positive) should be disinfected as soon as possible (refer to PIDAC Routine Practices and Additional Precautions in All Health Care Settings for more information about environmental cleaning).

5. Cleaning, Disinfection and Waste Management

- Staff engaged in environmental cleaning and waste management should wear appropriate PPE. For droplet precautions, a surgical mask may be worn,

as well as gloves, goggles and gown. An N95 respirator is only needed for airborne precautions (e.g., in negative pressure room or other rooms where AGMPs have been performed.)

- Staff may need to wear face shields and/or utility gloves, depending on the cleaning products (e.g., disinfectants) being used and/or mixed.
- Regular cleaning followed by disinfection is recommended, using hospital-grade disinfectants[§] with broad-spectrum virucidal activity; cleaning frequently touched surfaces in in-patient rooms is particularly important.
- If there is a shortage of hospital-grade disinfectants, decontamination may be performed by first cleaning with a detergent followed by a dilution of bleach to a chlorine concentration of 1,000 ppm. For this, a solution of one-part bleach to 50 parts water should be used, using household bleach (5.25% sodium hypochlorite). It is important to ensure that bleach has not expired.
- Use of the Public Health Ontario Chlorine Dilution Calculator is recommended: https://www.publichealthontario.ca/en/health-topics/environmental-occupational-health/water-quality/chlorine-dilution-calculator.
- Surfaces that may become damaged by sodium hypochlorite may be cleaned with a neutral detergent, followed by a 70% concentration of ethanol.
- Recommended contact time for bleach solution or ethanol is 10 minutes.
- Most waste should be treated as infectious clinical waste and handled in accordance with healthcare facility policies and local regulations.
- Facial tissues may be disposed of as normal waste; a lined touch-free receptacle is preferred.
- Surface types are important to consider when determining frequency of cleaning and disinfecting.
- High-touch surfaces may include doorknobs, handles, elevator buttons, light switches and computer keyboards/mice that are touched frequently throughout the day. High-touch surfaces require frequent cleaning and disinfection at least twice daily, and more frequently where the risk of contamination is higher than usual (e.g., if there is increase in illness at the site).
- Low-touch surfaces may include floors, walls and windowsills that are touched less frequently with hands throughout the day. Low-touch surfaces require cleaning on a regular (but not necessarily daily) basis and require immediate cleaning when visibly soiled.

[§] Such disinfectants will have a Drug Identification Number (DIN), with the exception of household bleach.

- For more information, please see: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet-covid-19-environmental-cleaning.pdf?la=en and https://www.publichealthontario.ca/-/media/documents/bp-environmental-cleaning.pdf.

Additional Sources:

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Appendix D: Frequently Asked Questions

Q1. What is a field hospital?

A field hospital is a temporary hospital in a tent-like or portable structure that is established for the provision of medical care. A field hospital is a type of alternative health facility which may be used in this COVID-19 emergency.

Q2. What functions might I use a field hospital or other alternate health facility for?

Hospitals may require additional capacity through alternate health facilities including field hospitals to manage the influx of patients in the COVID-19 emergency. Hospitals may consider using alternate health facilities for inpatient care including ALC, medically stable, general rehabilitation, complex continuing care or recovering COVID-19 patients. Hospitals may also consider re-locating ambulatory care programs from their main sites to alternate care facilities to create capacity within their main sites.

It is important for hospitals to select and establish premises with due regard to their suitability for the intended purpose (in view of current system challenges) and for the safety of patients, hospital staff and others.

Q3. Who does the hospital need to notify if it requires an alternate care facility?

The hospital should discuss their plans with their Ontario Health Regional Lead and inform the Ministry of the final plan.

Q4. What data and reporting requirements do I need to provide to Ontario Health and the Ministry?

The Ministry requires the following information about the alternate care facility.

- Address (including unit number, floor if applicable)
- Telephone number (if available)
- Purpose for the premises
- Number of beds being operated on the premises

- Any details respecting rents, copy of lease or licence agreement

In addition, any beds activated in alternate health facilities should be included in overall counts submitted to the daily bed census for COVID-19, by bed type.

Q5. Why do you need the address and telephone number of the location?

The Ministry requires the address and telephone number of each location to inform the Central Ambulance Communication Centres, Emergency Medical Services and Ornge. This will help facilitate the dispatch of ambulances as required to these locations.

Q6. Will the hospital be reimbursed for any expenses related to these alternate health facilities?

The Ministry has committed to reimbursing hospitals for COVID-19 related expenses and is working with both Ontario Health and the Ontario Hospital Association to ensure the proper tracking of all expenses, including those related to the use of retirement home locations.

Q7. The blanket waiver of the *Public Hospitals Act* (PHA) s. 4(2) has an end date of June 30, 2020. What if the only lease arrangement I can negotiate includes an end date that extends past June 30, 2020?

The approval is currently in place until June 30, 2020. Hospitals should ask all partners to be flexible, fair and as accommodating on setting lease or licensing terms during this state of emergency. As we work with Public Health Officials and hospitals leaders throughout the next few weeks, the Ministry will revisit the terms of the blanket s. 4(2) PHA approval waiver.

Q8. Does the hospital require new or revised hospital classifications under s. 32.1(1) of the PHA during the COVID-19 emergency?

No. On March 30, 2020, the Ministry communicated that it will not be using its discretion under s. 32.1(1) of the PHA to assign classifications to hospitals or revise classifications. Hospitals can proceed to operate as necessary to meet the demands arising from the COVID-19 emergency in the absence of such classification

assignments and revisions. Hospitals can operate an alternate care facility absent a classification.

This approach remains in effect with the general approval under s. 4(2) of the PHA until June 30, 2020 unless it is revoked earlier.

Q9. If my hospital needs a cash advance to support me securing an alternate care facility, can the Ministry of Health support us?

Yes, the government is prepared to support cash advances as required. Please follow normal request protocols.

Q10. What role will Infrastructure Ontario play?

IO can assist local hospitals at both identifying public assets that might be available for capacity expansion and/or assist hospitals in securing the necessary construction and project management services to erect a new temporary location such as a field hospital.