



*Caressant Care Nursing  
and Retirement  
Homes Limited*

# Pandemic Plan

FEBRUARY 2022, NOVEMBER 2022

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### **Purpose of Plan**

A Pandemic is identified as a specific hazard that could imminently disrupt the operations of the Long-Term Care Homes, Retirement Residence, the health care system, and society. It is a potential emergency that requires staff be knowledgeable and equipped with the necessary resources to be able to respond to the presenting situation.

### **Goal of Plan**

- To reduce the spread of virus/contagion among Residents, team members, family members and volunteers.
- To maintain essential care and services for Residents during a pandemic in order to keep them in the Home.
- To ensure that workplace health and safety standards are maintained to support team members, families and volunteers in meeting Resident care and service needs.

## Pandemic vs. Outbreak

Pandemic	Outbreak
<p>An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.</p> <p>Global pandemic — one that has spread over several countries or continents affecting a large number of people.</p>	<p>A number of cases that exceeds what would be expected.</p> <p>The case definition in an outbreak is dependent on the presenting signs and symptoms and circumstances. It may vary between outbreaks and also vary during an outbreak.</p> <p><b>Enteric Outbreak:</b> Symptoms must not be attributed to another cause (e.g., medication side effects, laxatives, diet or prior medical condition) and are not present or incubating upon admission and at least one of the following must be met:</p> <ul style="list-style-type: none"> <li>• Two or more episodes of diarrhea (i.e., loose/watery bowel movements) within a 24-hour period OR</li> <li>• Two or more episodes of vomiting within a 24-hour period; OR</li> <li>• One or more episodes of diarrhea AND one or more episodes of vomiting within a 24-hour period.</li> </ul> <p><b>Confirmed Respiratory Infection Outbreak:</b></p> <ul style="list-style-type: none"> <li>• Two cases of acute respiratory infections (ARI) within 48 hours with any common epidemiological link (e.g., unit, floor), at least one of which must be laboratory confirmed; OR</li> <li>• Three cases of ARI (laboratory confirmation not necessary) occurring within 48 hours with any common epidemiological link (e.g., unit, floor).</li> </ul> <p><b>Suspect Outbreak Definition*</b>Suspect respiratory infection outbreak:</p> <ul style="list-style-type: none"> <li>• Two cases of ARI occurring within 48 hours with any common epidemiologic link (e.g., unit, floor); OR</li> <li>• One laboratory-confirmed case of influenza.</li> </ul> <p>Note – definitions of outbreaks may change during the course of the pandemic- above are general guidance statements.</p>

Balzer. D. (2016) Pandemic vs Endemic vs Outbreak: Terms to know.

## Policies to Know

### Internal Policies & Procedures

In addition to this pandemic guide, all team members and Home leadership should be familiar with and apply the existing policies, including but not limited to:

- Outbreak Management
- Hand Hygiene
- Donning & Doffing PPE
- Admission
- Dining
- Laundry
- Reception of Goods
- Existing Daily Tools/Checklists
- Team Contingency Plans
- Visiting Routines

### Mandatory Government Policies, Guidance Documents & Directives

During the course of a pandemic, various provincial and/or federal government policies, guidelines and directives may become a requirement of practice or implementation for the Homes. Please note that all these policies apply until they are reversed. When new guidance involves significant change, ensure this document is updated (including updates tracking), and communicate the change with stakeholders impacted by the change.

Date	Description	Source
<b>This list was last updated on:</b>		

## Prevention & Preparedness

This section outlines the best practices and guidelines all team members should be familiar with to prevent and prepare for an outbreak during a pandemic. It is important to note that prevention and preparedness measures will stay in place if an outbreak is declared.

### Screening

During a pandemic, screening of team members, family, volunteers, and visitors to the Homes is generally a requirement. The table below outlines some steps/processes to consider when implementing a screening program.

#	Steps to Implement	Done
1	<p><b>All individuals entering the facility should be screened, seven days a week 24 hours a day</b>, including team members, essential visitors, suppliers, etc. Entry cannot be granted without screening. The screener must:</p> <ul style="list-style-type: none"> <li>• <b>Log all entries</b> to the facility</li> <li>• <b>Ask about symptoms</b></li> <li>• Ask about potential <b>close contact</b> with symptomatic or infected individuals*</li> <li>• Perform <b>temperature check</b> (37.8°C or more is considered a fever) if required</li> </ul> <p>Anyone who does not pass a screening will not be allowed to enter, should self-isolate and contact their managers. Note: Emergency first responders should be permitted entry without screening.</p>	
2	The Home should <b>designate a screener during regular business hours</b> . During busy times (e.g., beginning of shifts), the screener should be at the entrance. Outside those times, alternatives can be used to call the screener to the door, but the doors should be locked or monitored (e.g., call button, phone number to call for someone to come to the door, etc.).	
3	All Residents are to be screened <b>daily</b> , including temperature checks. Log in PCC (or template if PCC not used). <b>Residents with symptoms or close contact are to be screened twice daily</b> . Screening may be increased based on MLTC/RHRA or PHU directives. Temperature checks may be included or removed as per MLTC/RHRA or PHU directives.	
4	All staff and essential visitors are to be screened <b>daily</b> . Screening may include temperature checks as per MLTC/RHRA or PHU directives. Screening may be increased based on MLTC/RHRA or PHU directives.	
5	Team members, volunteers, and essential visitors should <b>self-assess</b> if they believe they may have been infected.	
6	A <b>central record of all screenings</b> should be maintained and <b>reviewed by leadership daily</b> .	
7	Screener should <b>wear at a minimum mask, eye protection and gloves</b> or be behind plexiglass partition, and have access to alcohol-based hand rub	
8	<b>Failed Screening: Isolate / Do not allow to enter the Home and handle as suspected case.</b> The home may choose to offer PCR testing to staff prior to going home.	

**See Appendix – Job Tasks – COVID-19 Door Screener and COVID-19 Screener Audit**

## Passive Screening & Signage

#	Steps to Implement	Done
1	<b>Signage across the Home:</b> <ul style="list-style-type: none"> <li>Reminders to perform hand hygiene</li> <li>Reminders to follow physical distancing etiquette</li> <li>Reminders to follow respiratory etiquette</li> <li>Signs and symptoms of illness (Pandemic type)</li> <li>Steps that must be taken suspected or confirmed in a staff member or a resident</li> <li>PPE donning and doffing visuals, as well as disposal instructions</li> <li>PCRA reminders at each room</li> <li>Display reminders and information on TV monitors in each Home area</li> <li>Visual reminders to perform point of care risk assessment (PCRA) prior to any resident interaction (recommend having at med carts, nursing stations, computers, entry of each Home area)</li> </ul>	
2	<b>Signage at entrances:</b> <ul style="list-style-type: none"> <li>Indicates building access directives</li> <li>Indicates that all non-essential visitors are not permitted entry until further notice (posted during an outbreak and as directed by PHU)</li> <li>Symptoms and reminder not to enter the LTCH if presenting any (symptoms), go home and isolate / get tested</li> <li>Reminders of precautions for team members outside the Home</li> </ul>	
3	<b>Physical distancing signage</b> and markers (e.g., footprints every 2m, tape lines on the floor) available in areas where staff or Residents tend to congregate (e.g., break areas, nursing station, computers, building entrance, etc.).	
4	Elevator signage (if applicable) to indicate maximum occupancy for physical distancing.	
5	Floor markers to indicate paths for clean and soiled laundry, PPE, etc. to avoid mixing both.	

## Physical Distancing

Physical distancing means maintaining a minimum distance of 2 meters from other individuals at all times to minimize close contact and transmission of diseases. Some routine changes may be required to apply physical distancing:

- Avoid handshakes
- Avoid crowded places and non-essential gatherings
- Limit contact with people at higher risk
- Keep 2 arm lengths from others (approximately 2m)

Based on MLTC/RHRA/ PHU various individuals may be excluded from time to time from having to practise physical distancing i.e., essential caregiver during periods of low pandemic activity.



## Working from Home

### Who Should Work from Home?

The Home should make every effort to facilitate work from home where possible to limit the number of people on site who could potentially bring in the disease. However, this cannot come at the cost of quality of care or team member health and wellness. The below outlines general recommendations as to who should and shouldn't work from home.

<b>Role</b>	<b>Recommendation</b>
<b>Admin / Leadership</b>	<ul style="list-style-type: none"><li>• Some team members in administrative functions may be able to work from home; decisions should be evaluated on a case-by-case basis by the RDO &amp; Operations Team</li></ul>
<b>Nursing / Care</b>	<ul style="list-style-type: none"><li>• Team members providing direct Resident care usually cannot work from home</li></ul>
<b>Medical / Physician</b>	<ul style="list-style-type: none"><li>• Physicians/medical officers and specialists may not be cohorted and can pose a great risk for transmitting infection given the number of Residents they typically see</li><li>• Remote consultations should be facilitated as much as possible</li><li>• Nursing/care team members in each cohort will need to be available to facilitate video conferencing (e.g., hold tablet from room to room)</li><li>• Physicians may still come on site where needed but should limit contact to a minimal number of Residents and use PPE</li><li>• It is recommended to weigh the risk of having physicians consult remotely (e.g., risk level of the population, impact on care, etc.) against the risk of transmission if onsite</li></ul>
<b>Recreation</b>	<ul style="list-style-type: none"><li>• Recreation team members should be cohorted and facilitate individual/in-room recreation programs</li><li>• If less recreation team members are required on site, consider whether additional team members can be redeployed (e.g., to environmental services)</li></ul>
<b>Environmental</b>	<ul style="list-style-type: none"><li>• Team members performing environmental duties (cleaning and disinfection, laundry, waste management) usually cannot work from home</li></ul>
<b>Dining</b>	<ul style="list-style-type: none"><li>• Team members performing dining duties (cleaning and disinfection, laundry, waste management) usually cannot work from home</li><li>• Dieticians can work from home</li></ul>
<b>Pharmacy</b>	<ul style="list-style-type: none"><li>• Team members performing pharmacy duties usually can work from home and should follow pharmacy specific policies</li></ul>

## Requirements for Team Members Working from Home

### Tools and Equipment

- Computer (policy should specify whether personal devices are allowed, or the Home will provide devices)
- Internet access
- VPN connection
- Conferencing tools / software (e.g., Microsoft Teams)
- Access to key programs (e.g., Office, PCC, HR system, etc.)
- Access to key information (e.g., schedules)
- Remote access / remote desktop if required (e.g., for local intranet)
- Re-route phone calls from office phone (may require IT support)

### Policies and Processes

- Security policies, especially for protecting employee and resident data
- Helpdesk / Contact for any issues encountered
- Clear guidelines on who to reach and for what, including method of communication (e.g., text for emergencies)

## Essential Resident Care Needs

During the pandemic, the Homes may need to implement staff contingency plans to complete the essential care and services required for Residents. The table below outlines areas of Resident care that need to be reviewed, acted upon, and maintained.

#	Steps to Implement	Done
1	Every health care worker must perform a <b>point-of-care risk assessment (PCRA)</b> before any resident interaction. <b>See Appendix – Routine Practices Risk Assessment Algorithm for All Client/Patient/Resident Interactions</b>	
2	Ensure Residents' <b>goals of care and Plan for CPR</b> are known and up to date (e.g., DNR, funeral arrangements, etc.).	
3	Ensure <b>resident care is maintained</b> under all circumstances, including: <ul style="list-style-type: none"> <li>• Personal care</li> <li>• Bathing can be done at the bedside, at a minimum once per week</li> <li>• Care of fingernails and feet may be rescheduled as required</li> <li>• Medication administration (compression should be completed with Pharmacy)</li> <li>• Ongoing assessment of care needs</li> <li>• Routine catheter care</li> <li>• Skin and wound management and colostomy care</li> <li>• Assistance with eating as required; G-tube feeding and maintenance</li> <li>• Oxygen therapy as required</li> <li>• Residents with mobility concerns and/or at risk for skin breakdown will be repositioned</li> <li>• Follow outbreak management policies</li> <li>• Advanced care planning will be followed and updated as required</li> <li>• Non-urgent medical appointments can be rescheduled</li> </ul> <b>Note – see appendix LTC Contingency Plan for Resident Care</b>	
4	Infection prevention discussions with RDO's may be needed for <b>increase in care/staffing</b> in the following areas: <ul style="list-style-type: none"> <li>• Dining Services</li> <li>• Bathing</li> <li>• Laundry</li> <li>• Housekeeping</li> </ul>	

### Point of Care Risk Assessment (PCRA)

A point of care risk assessment (PCRA) assesses the task, the Resident and the environment. A PCRA is a dynamic risk assessment completed by the team member before every Resident interaction to determine whether there is risk of being exposed to an infection.

Performing a PCRA is the first step in Routine Practices, which are to be used with all Residents, for all care and interactions. A PCRA will help determine the correct PPE required to protect the team member in their interaction with the Resident and Resident environment.

## **Cohorting – Team Members & Residents**

In the event of a pandemic, team member and/or Resident cohorting may need to be implemented in order to contain the spread of the virus/contagion.

**Cohort:** In this document, we refer to a cohort as a group of people who have or may have symptoms or are similar risk of development symptoms.

**Cohorting:** Group Residents based on their outbreak status or risk of symptoms during an outbreak. Cohorting is a way to help prevent the spread of infection within the facility. Where possible, and in accordance with other requirements of the facility, move Residents in each cohort to separate areas of the facility.

**Team Member Cohorting:** Having a staff member look after only one cohort of Residents and not moving from one cohort to another. It is preferable to move Residents from the same cohort to the same area of the building to make it easier for staff to look after only one cohort. However, if it is not possible to move Residents, team member cohorting can still be implemented with a team member looking after only the Residents in one cohort and not moving from one cohort to another during a shift.

**Outbreak and Non-Outbreak Areas:** The outbreak area has cases or may have cases soon, such as floors/units where there are Residents or staff with symptoms or who may have been exposed to the outbreak. The non-outbreak area is the remainder of the facility. In some outbreaks, the whole facility is considered the outbreak area.

## **Team Member and Resident Cohorting**

Homes must have a plan for team member and Resident cohorting (to the best of their ability) as part of their approach to preparedness as well as to prevent the spread of the outbreak once identified in the facility.

### **Resident Cohorting may Include:**

- Alternative accommodation in the facility to maintain physical distancing of 2 meters.
- Resident cohorting by outbreak status.
- Utilizing respite and palliative care beds and rooms or other rooms as appropriate
- Consideration to ensuring Residents programs and dining promote social distancing
- Workflow should be organized so care to the cohort is grouped together, to minimize repeated visits to the same cohort
- If team members must move between the cohorts, they should only go from the lowest risk cohort to the highest risk cohorts if at all possible.

### **Team Member Cohorting may Include:**

- Designating team members to work consistently in specific areas in the Home as part of preparedness.
- If possible, team members should be assigned to care for only one cohort of Residents during each shift. If it is not possible to move Residents, staff cohorting can still be implemented, with a team member only looking after the Residents in one cohort during a shift.
- Over the course of the outbreak, if possible, team members should work with only one cohort, and not switch between cohorts.
- If in an outbreak ensure team members have access to supplies and rest areas and do not access other areas that are not in outbreak

- Designating team members to work only with specific cohorts of Residents based on their outbreak status in the event of suspected or confirmed outbreaks: With preference for exposed asymptomatic team members to care for outbreak positive Residents, if possible
- If PPE is in short supply, not all PPE needs to be changed when working within a cohort; therefore, team cohorting helps reduce the use of PPE
- Designate asymptomatic team members with no exposure to ill Residents to caring for asymptomatic Residents not exposed to a case.
- In smaller facilities or in facilities where it is not possible to maintain physical distancing of team members or Residents from each other, all Residents or team members should be managed as if they are potentially infected and staff should use droplet/ contact precautions when in an area known to be affected by the outbreak.
- Stagger team breaks to promote social distancing and rearranging furniture in team lounges to provide distance when required
- Team members working with one cohort should remain separate from each other and from team members working with other cohorts. **It is particularly important for team members to stay at least two meters from each other at all times, including during breaks and meals.** Each team cohort should use the team lounge at separate times if possible. If possible, frequently touched staff lounge surfaces like table tops and chair arm rests should be cleaned between cohorts.
- Team members who were exposed to the outbreak area, particularly without the use of appropriate PPE (e.g., worked in the outbreak area before the outbreak was recognized) and have subsequently been cleared to return to work, should not work in the non-outbreak area.

## Building & Physical Layout

#	Steps to Implement	Done
1	<p><b>Limit number of public entrances</b> to the building. All entrances should be monitored 24/7.</p> <ul style="list-style-type: none"> <li>• <b>One-single-point of entry:</b> Easier to implement but occasionally poses higher risk if multiple team members show at the door at the same time.</li> <li>• Separate entrances for different purposes (e.g., ill vs. well units): This approach requires more oversight</li> </ul> <p>Note: Ideally, only one entrance is accessible for all team members and visitors, and all others are locked with signage redirecting to the main access. Exceptions can be made to provide access for team members to a self-contained isolation area to promote separation of infected and non-infected areas' team. These entrances should also be monitored 24/7 and all those entering should be screened.</p>	
2	<p><b>Access to the community</b> is to be limited to team members (employees, volunteers, agency staff) and essential visitors</p>	
3	<p>A <b>process should be in place to record all who enter and exit</b> the Home, including essential visitors (full name, contact information, Resident visited, in/out time). This can be done by the same person performing entrance screening</p>	
4	<p>Ensure <b>elevators (if applicable) are disinfected between each use</b> (buttons, bars, anything touched with Oxivir wipes) and avoid leaning on walls of the elevator. Place disinfecting wipes in or near the elevator. If possible, separate elevator use by purpose, (e.g., "Clean" elevator (e.g., for all non-positive Residents, staff, clean goods), "Soiled" elevator (e.g., soiled laundry), Food Elevator (strictly for food and dietary team to protect the kitchen)).</p>	
5	<p><b>Move / remove seating</b> in common areas to ensure physical distancing</p>	
6	<p><b>Reconfigure dining areas</b> where necessary to ensure physical distancing is maintained for all Residents Note: Separate sittings may be required</p>	
7	<p><b>Place markers</b> on the floor and across the Home to promote physical distancing (keep 2m apart), especially in high traffic areas:</p> <ul style="list-style-type: none"> <li>• E.g., Nursing station, Elevator waiting area, Bathrooms, Kitchen, team lounges, Entrance, smoking areas, etc.</li> <li>• See example breakroom measures below</li> </ul>	
8	<p><b>Alcohol-based hand rub</b> should be placed:</p> <ul style="list-style-type: none"> <li>• Outside any room where there is a suspected or confirmed case</li> <li>• At the building entrance</li> <li>• At dining room entrances</li> <li>• In care areas</li> </ul>	
9	<p>Place the following <b>items at the entrance</b> of the building:</p> <ul style="list-style-type: none"> <li>• Alcohol-based hand rub (ABHR) with 70- 90% alcohol concentration</li> <li>• Tissues</li> <li>• Procedure masks</li> <li>• Proper use signage</li> <li>• No touch waste receptacle</li> </ul>	

## **Education and Training**

To ensure that team members have the knowledge and skills to reduce transmission, employers must provide appropriate education and training. Ongoing education and support are key to workplace health and safety.

Education programs should be developed in consultation with and be reviewed by the Joint Health and Safety Committee/Health and Safety representative.

### **Team member education should include but is not limited to the following:**

- Routine IPAC Practices
- Hand Hygiene – How to Handwash, How to Hand Rub
- Point of Care Risk Assessment (PCRA)
- Donning & Doffing of PPE
- Cough Etiquette
- Infection Control & Prevention Measures
- Social Distancing
- How to Self-Isolate

### **Resident, Family and Volunteer Education:**

The infection control program lead and/or designate will collaborate to deliver education to Residents, families and volunteers. This education will include but is not limited to the following:

- Hand Hygiene – How to Handwash, How to Hand Rub
- Cough Etiquette
- Infection Control & Prevention Measures
- Donning and Removing of Personal Protective Equipment (PPE)
- How to Self-Isolate
- Social Distancing
- Altered Roles & Assistance with ADL (as posted by the facility)
- Feeding Programs

### **Educational materials can be accessed from the following:**

- Local Public Health Unit
- Public Health Ontario
- Ontario Government
- PIDAC
- IPAC

**Educational resources can also be sent via ONE Call.**

## Response Levels During a Pandemic

### 1. Pandemic Activity in the Community

- The local Public Health Unit will notify the Home that the pandemic has spread into the area
- The Home will activate its emergency plan if appropriate (note that there may be a loss of essential community services)
- Homes will maintain active surveillance using the local Public Health surveillance forms.

### 2. Pandemic Activity in the Home

When an outbreak of the Pandemic strain is suspected or confirmed in the Home, the Home will take the following steps:

- 1) Notify the local Medical Officer of Health or their delegate
- 2) Implement infection prevention and control measures
- 3) Notify appropriate individuals
- 4) Hold an initial meeting of the Outbreak Management Team (OMT)
- 5) Monitor the outbreak / continue ongoing surveillance
- 6) Implement control measures for Residents
- 7) Implement control and support measures for the staff and volunteers
- 8) Pharmacy – Medication Management & Antivirals
- 9) Media & Communication
- 10) Emergency Supplies/Stockpiling Plans
- 11) Implement control measures for visitors
- 12) Mass Fatality Management
- 13) When the outbreak is over?
- 14) Investigate & review the outbreak
- 15) Complete 24 hr outbreak checklist



## Steps Involved – Pandemic Activity in the Home

### 1. Notifying the Local Medical Officer of Health or Designate of Potential Outbreak

- Notify the local authorities by phone about the potential or confirmed outbreak
- Submit the outbreak reporting forms to the Medical Officer of Health or their designate
- Give the Medical Officer of Health (or designate) the name of the primary Infection Control Practitioner and backups at the Home for the outbreak investigation along with their contact information by fax
- Report the initial control measures that have been implemented
- Request an investigation number (Outbreak Number) and record it on all laboratory submissions forms
- Review with the local Public Health Unit – If and which Residents are to be tested, how to get additional sampling kits, how many and which specimens will be collected and how they will be stored and then submitted to the lab.
- Notify the MLTC regional office and continue to activate the pandemic plan.
- Notify the Ministry of Labor
- Notify Head Office

### 2. Implement Infection Control Measures

#### Personal Protective Equipment

- Each Home will provide an adequate supply of personal protective equipment (PPE) to team members, families, volunteers and students.
- The PPE must be readily accessible and available to team members at all times during the suspected outbreak, heightened surveillance and declared outbreaks
- Each Home should attempt to maintain a 2-week supply of PPE. During a pandemic outbreak, each Home may have access to a MOH PPE stockpile by initiation of contact with the Ministry Emergency Operations Centre.

#	Steps to Implement	Done
1	Team members should receive <b>training on PPE use</b> and proper donning / doffing procedures.	
2	<ul style="list-style-type: none"> <li>• <b>Masks:</b> Homes should immediately ensure that <b>all team members</b> wear surgical/procedure masks at all times. This is required for all Homes; those in outbreak and those not in outbreak. Masks should be placed near the entry to the Home.</li> <li>• Team members who enter Resident areas are to be given <b>2 masks per shift</b> minimum</li> <li>• Team members who do not enter Resident areas are given <b>1 mask per shift</b> minimum</li> <li>• Masks should be <b>replaced if they become soiled or moist</b> (e.g., when sneezing), or after interacting with a Resident with a suspected or confirmed case</li> <li>• For team members who are taking breaks, the surgical/procedure mask may be removed but a minimum two-meter distance should be maintained from others</li> </ul>	

	<ul style="list-style-type: none"> <li>• <b>Residents</b> should be asked to wear masks as tolerated and/or asked to wear a face shield especially in common areas. They should be given a mask if going out for appointments / hospital, or if being moved within the facility and suspected or positive.</li> <li>• <b>Essential visitors</b> must also wear a surgical/procedure mask at all times while in the Home – the Home will provide masks at the point of entry.</li> <li>• <b>Note -masking mandates may change based on Ministry directives and or best practices</b></li> </ul>	
3	All team members should have undergone <b>N95 fit</b> testing	
4	<p><b>PPE: Contact and Droplet Precautions</b> require PPE. Contact/Droplet precautions PPE should be available outside isolation rooms (and units where appropriate) and used when providing care to a Resident <b>suspected or confirmed</b> of having contracted the disease. Contact/Droplet precautions PPE includes:</p> <ul style="list-style-type: none"> <li>• Surgical/procedure mask</li> <li>• Goggles or Face shield</li> <li>• Gown</li> <li>• Gloves</li> <li>• N95 Masks as directed by MLTC/RHRA/PHU directives</li> </ul>	
5	For aerosol generating medical procedures ( <b>AGMP</b> ), Airborne precautions should be taken, which include <b>Contact/Droplet precautions PPE and N95 respirators</b> (instead of surgical mask).	
6	Proper <b>receptacles</b> (no touch ideally) should be put in place to gather used PPE inside the isolation room near the exit and throughout the Home, and no PPE is to be reused in a separate room.	
7	When Droplet and Contact precautions are in place (suspected or confirmed cases), <b>condense Resident care</b> where possible to reduce Resident touchpoints and limit PPE use (e.g., screening with morning care).	
8	Assess <b>PPE</b> requirements based on Resident touchpoints.	
9	<p>Procure a minimum of <b>14-day supply of PPE</b> on an ongoing basis. In prevention, PPE levels are recommended to be sufficient for 14 days of outbreak measures in one unit. Once in outbreak, procure 14-day supply for all areas in outbreak.</p> <p>Note: This may require a dedicated role as shortages are widespread. Several suppliers should be identified, and orders may need to be placed for several months in the future. Communicate with vendors when in outbreak as they may be able to prioritize orders.</p>	
10	<p>Implement process for <b>tracking of PPE availability</b></p> <ul style="list-style-type: none"> <li>• Option 1: Have team submit daily count of PPE used and tally for entire facility</li> <li>• Option 2: Keep count of PPE levels in storage and update as supplies are restocked/used</li> </ul> <p>Report PPE levels to authorities as required.</p>	
11	PPE should be stored in a secure location to avoid theft and unnecessary use.	

**Note:**

PPE may frighten Residents, particularly those who are cognitively impaired. Team members can introduce themselves at the Resident’s doorway prior to donning and notify the Resident that they will be entering the room with a face shield and gown. **See Appendix – Person Behind the Mask**

All team members should be trained on donning and doffing procedures as outlined below, and signage should be placed near donning/doffing stations to remind team members of steps. Regular audits and refresher training should be performed throughout a pandemic. **See Appendix – Donning & Doffing PPE**

**PPE Conservation: Extended Use & Reuse**

PPE shortages may occur in pandemics. If the Home is experiencing shortages, they may choose to implement the following conservation measures. Note that these are not standard practices for PPE and should not be used unless there is a shortage. **Always follow direction from IPAC Officer or delegate when it comes to PPE conservation.**

PPE	Conservation Measure	Done
<b>Surgical Mask</b>	<ul style="list-style-type: none"> <li>As long as masks are not soiled, wet or dirty, they can be worn to provide care to several Residents (extended use).</li> <li>Masks should be changed when soiled, or when moving between COVID-19 positive/suspected Residents and other Residents.</li> <li>Masks may be kept in paper bags or between paper plates for later reuse if necessary (e.g., during break)..</li> </ul>	
<b>Eye Protection</b>	<ul style="list-style-type: none"> <li>As long as eye protection is not soiled, wet or dirty, it can be worn to provide care to several Residents (extended use) – note that eye protection is generally not required when not in outbreak.</li> <li>Eye protection should be changed when soiled, or when moving between positive/suspected Residents and other Residents.</li> <li>Reusable eye protection requires no extended use measures – it should always be washed and disinfected between uses.</li> <li>Some disposable eye protection may be reused but should be reused by the same staff member and washed and disinfected between uses (recommend writing names of staff on shield in permanent marker).</li> <li>Some face shields with soft foam parts should only be washed on the plastic part as the foam will get damaged if washed.</li> <li>Once visible damage appears on a reusable shield, it should be disposed of.</li> </ul>	
<b>Gloves</b>	<ul style="list-style-type: none"> <li>Gloves should never be reused between Residents and should be disposed of after use.</li> </ul>	
<b>N95 Masks</b>	<ul style="list-style-type: none"> <li>N95 Masks should be worn when providing care to Residents with suspected or confirmed COVID-19 and when providing AGMP.</li> </ul>	
<b>Gowns</b>	<ul style="list-style-type: none"> <li>Gowns should be changed between each Resident.</li> <li>Reusable gowns (if applicable) should be washed between each use.</li> <li>Disposable gowns can generally not be washed and should be disposed of after use.</li> <li>If necessary, one gown can be used for multiple confirmed positive Residents.</li> </ul>	

**Hand Hygiene**

Hand hygiene practices are one of the most important measures in stopping the spread of infections. All staff must be trained on hand washing and the use of Alcohol Based Hand Rub (ABHR). All staff must be following

the 4 Moments of Hand-Hygiene. Homes should audit hand hygiene practices throughout the course of the pandemic. **See Appendix – 4 Moments of Hand Hygiene.**

### Cleaning & Disinfecting

Cleaning and disinfection are one of the key measures to combat a pandemic. All team members should follow basic cleaning protocols outlined below, in addition to the enhanced cleaning and disinfection taking place.

The following need to be reviewed/considered:

- *Contact supplier to determine level of cleaning agent to use and contact time.*
- The Homes will use infection control and cleaning procedures according to pandemic type
- Assign responsibilities and accountability for routine cleaning of all environmental surfaces
- Review disinfection methods
- Resident care items should be cleaned & disinfected between Resident use
- All horizontal and frequently touched surfaces should be cleaned daily & more often (**See Appendix – Daily High-Touch Point Cleaning Checklist**)
- Routine practices should be applied in the handling of soiled linen (note proper PPE must be available and worn by team members). **See Appendix – Laundry Audit**
- Routine practices should be applied to handling clinical wastes
- Use disposable equipment whenever possible.

### Waste Management

#### Important to Know

Following routine practices such as:

- Ensure staff are follow Routine Practices
- PPE should be worn when handling (open) soiled linen, including: Gowns, Goggles, Gloves/Face Shield
- Consider all soiled laundry / clothing as potentially infectious
- Ensure soiled linen / clothing does not contaminate clean linen

#	Steps to Implement	Done
1	Put in place waste management schedule reflecting needs of the Home during the pandemic times <ul style="list-style-type: none"> <li>• Policies and procedures regarding staffing in Environmental Services departments should allow for surge in waste (e.g., additional PPE).</li> </ul>	
2	Ensure that team members are familiar with waste management handling and controls: <ul style="list-style-type: none"> <li>• Perform Hand Hygiene after handling waste; always use gloves</li> <li>• Watch for anything sticking out of the bag or waste containers</li> <li>• Never dump waste from one receptacle/bag to another</li> <li>• Tie garbage bags before removing from the waste receptacle, never dump waste from one bin to another</li> <li>• Never reach into, or ‘push’ on the bag, to push the garbage down</li> <li>• Carry the garbage bag away from your body (hold bag by the knot/ties)</li> </ul>	

	<ul style="list-style-type: none"> <li>If the bag of garbage is heavy and/or there is a chance the bag may break or leak, use a double/bag method</li> </ul>	
3	Ensure that every Resident room/bed area has a covered waste receptacle	
4	Ensure that waste management has necessary supplies (including planning and re-ordering) <ul style="list-style-type: none"> <li>E.g., garbage bags</li> </ul>	
5	Work with HR to support team morale	
6	Use required/ designated biohazardous waste bags for all biohazardous waste.	

3. **Notify Appropriate Individuals:** The Home will notify those individuals associated with the facility.

Individuals to Contact	Contacted
Medical Director/Attending Physicians/Nurse Practitioners	
Home's Leadership Team – ED, DOC, FSM, ESM, Dietary, Rec/Program	
IPAC Lead & IPAC Committee	
Ministry of Long-Term Care (Initiate Critical Incident Report)/ RHRA	
Ministry of Labour (if staff affected)	
JHS Team	
Caressant Care Head Office- via Risk Alert Email	
Frontline Team Members	
Unions & Union Representatives	
Residents & Families	
Volunteers	
Pharmacy	
Lab Services	
Resident & Family Councils	
LHIN	
Other Service Providers/Contracted Services - OT/PT, footcare, hairdresser	

#### 4. **Outbreak Management Team (OMT)**

##### Important to Know

The Outbreak Management Team (OMT) is **responsible for:**

- Identifying, declaring and providing direction when an outbreak occurs
- Outlining an action response to the infection and outbreak
- Providing analysis that focuses on successes or areas of improvement
- Reporting to ICP or designate in the Home and all authorities

The OMT should **meet within 24 hours** of notifying the Public Health Department/Ministry of Health or as instructed by authorities; Executive Director or designate to activate team.

## **Outbreak Team Initial Meeting**

Coordinate an Initial Outbreak Management Team (OMT) to manage the outbreak and discuss the following:

- Assignment of key roles – Chairperson, Secretary, Outbreak Coordinator, Media Spokesperson
- Develop working case definition
- Determine appropriate signage is posted to notify visitors of outbreak status and to remind staff of precautions and who is responsible for posting
- Confirm Antiviral Meds as required
- Confirm implementation of team member exclusion policy as required
- Confirm implementation of team contingency plan as required
- Confirm process for specimen collection
- Identify any further notifications
- Review communication plans – internal & external
- Determine if in-service sessions for team members are required and who will conduct them
- Confirm how and when daily communication will take place with PHU and the Home
- Confirm who is responsible for PHU update daily
- Line listing – update as necessary and share with PHU daily
- Review control measures to prevent spread
- Enforce use of PPE
- Initiate screening if required by PHU
- Confirm frequency and times of outbreak meetings

## **See Appendix – Initial Pandemic Outbreak Meeting Template**

### **5. Monitor Outbreak/Surveillance**

- Each Home should use the tracking surveillance forms approved by their local Public Health Units
- Track the spread & impact of outbreak
- Monitor ongoing transmission and effectiveness of infection control measures
- Recommend needed changes to program
- Confirm population at risk in the facility
- Total number of Residents, team members, volunteers
- Homes may find it useful to keep separate line listing surveillance forms for: each home area, and for team members with symptoms

### **Resident Surveillance**

The following information will be collected:

- New cases
- Residents who have recovered
- Status of ill Residents
- # of Residents receiving anti-viral prophylaxis
- Adverse reactions to any prescribed anti-viral medications
- Transfers to acute care hospitals
- Status of NP swabs
- Deaths

## Team Member Surveillance

The following information will be collected:

- New team member cases
- Team members who have recovered and return to work date
- Status of ill team members
- # of team members receiving anti-viral
- Adverse reactions to any prescribed anti-viral
- Status of NP swabs
- Deaths
- Team members still with symptoms, but who may be able to work in the Home with restrictions

**See Appendix – Caressant Care Occupational Illness/ COVID-19 Outbreak Tracking Form**

## 6. Implement Control Measures for Residents

### Resident Appointment, Vacations, and Hospital Transfers

During a pandemic, requirements, practices, and protocols that allow Residents to leave the Home, attend a medical appointment, take an LOA/vacation and/or be transfer to a hospital are likely to be directive by government health authorities. Homes should expect that at a minimum the following may be implemented:

#	Steps to Implement	Done
1	Residents are <b>not permitted to leave the Home</b> for short-term absences, vacation, appointments (e.g., visit family or friends) unless for prescribed medical reasons (e.g., dialysis, transfusions, etc.).	
2	If a Resident leaves the Home for an <b>outpatient visit or hospital transfer</b> , the Home must mask the Resident if they tolerate it.	
3	When a Resident returns, they should be <b>managed as per Ministry directives/guidance documents. Some actions may include:</b> <ul style="list-style-type: none"> <li>• Application of PPE</li> <li>• Screen Resident before entry to the facility</li> <li>• Provide them with a mask</li> <li>• Bring them directly to their room</li> <li>• Shower the Resident (including washing hair)</li> <li>• Change and wash their clothes</li> <li>• Put in appropriate precautions</li> <li>• Isolate in room for XX day if required</li> <li>• Request tray service</li> <li>• Screen for 48-72 hours post-arrival (or prescribed window before testing new infection)</li> </ul> <p>Note: For Residents with frequent outpatient visits, they may require isolation throughout the pandemic</p>	
4	If a Resident who is a suspect or confirmed case, is referred to a hospital, the Home should coordinate with the hospital, local PHU, paramedic services and the Resident to maintain appropriate isolation precautions during travel.	
5	Notify family if Resident is to be transferred to hospital.	

6	Patient transfer services should not be used to transfer a suspected or confirmed case.	
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**Transfer to Hospital will be required if:**

- A Resident required care involving supplies, equipment or skill set not available in the Home and which cannot be brought into the Home.
- Surgery is likely to be required to address the care needs (i.e., fracture is suspected).
- A Resident is not palliative but has experienced a life-threatening event.
- Medical Director/NP has determined that transfer to hospital is necessary.

The importance of following the established transfer authorization processes when transferring Resident to hospitals or to another health care facility will be paramount. – (i.e., on-line completion of PTAC form or by calling PTAC at 1-833-401-5577). Where at all possible transfers to ER/hospital should be limited.

**Criteria for Resident Relocation**

- May be determined by government directives
- An assessment of care needs to determine where the Resident will be best cared for
- Residents receiving renal dialysis emergency orthopedic surgery etc. will be evaluated to determine the best location to meet their care needs.
- Some Residents may be able to be safely discharged to the community due to increased surge capacity
- If a Resident has been determined eligible to go Home with family members, the Registered team members, in conjunction with the DOC, will provide support, education, medication and personal care items to support the transfer Home. This will not be considered as a discharge to community unless the family/Resident wishes a permanent discharge.

Additionally, some Homes may be contacted to consider the intake on non-acute patients from hospitals in an effort to free up acute care beds. Considerations for this should be made in conjunction with the Corporate Head Office.

**7. Implement Control Measures for Team Members & Volunteers**

**Human Resources Management – Policies to Consider**

In the event of a pandemic, labour legislations (i.e., *Employee Standards Act of Ontario*) and collective agreements will continue to guide decisions. Unions will be consulted with respect to labour issues impacted on by the Pandemic outbreak. The following policies/issues may need to be addressed:

- Absenteeism
- Refusal of Work
- Overtime
- Sick leave
- Return to work
- Compensation
- Cross training of tam members
- Redeployment of team members
- Vacation entitlements



## Team Contingency Plan

It is anticipated that all team members will continue to report to their normal duties unless specific directions are otherwise given. The use of volunteers, students, and family members to assist in the provision of Resident care will be reviewed/considered as required.

The Home outbreak team will oversee the redeployment, education and cross training of available team members, volunteers, family members & students.

Specific services and programs may be suspended to make additional team members available to assist with the essential services. Agency staff may be used to fill team member vacancies as required. Alternate work assignments may be considered to maintain essential services.

**See – Team Contingency Plan for the Home.**

**See Appendix – Critical Staffing – Resident Care Contingency Plan for OLTC**

The DOC/designate will maintain the list of cross trained team members. **See Appendix – Team Cross Training**

## Team Member Support Services

In conjunction with the Homes' ED, RDO and Head Office, decisions regarding the availability of additional team support services will be made. Some support that could be provided may include:

- Onsite childcare
- Transportation services
- Meals
- Overnight accommodation
- Rest areas between overtime shifts

## Team Wellness Support

Frontline team members need to be mindful of their own health and wellness, including pandemic related stress and anxiety, compassion fatigue, and exhaustion. Several resources are available for workers to get **help and support to help with mental health**. Note that these resources are available both for pandemic related issues as well as general mental health.

Resources	Notes	Contact
EAP	Existing Corporate EAP	
ConnexOntario – Ontario Mental Health Helpline	24/7 Chat also available: <a href="https://www.connexontario.ca/">https://www.connexontario.ca/</a>	1-866-531- 2600
Canadian Mental Health Association Crisis Help Line	24/7 Also available via text: 45645	1- 833-456-4566
CAMH Mental Health Supports for Healthcare Workers	CAMH is providing access to mental health and addiction supports for health care workers These services include access to resources, Cognitive Behavioural Therapies (CBT/Psychotherapy) as well as Psychiatric Services.	<a href="https://redcapsurveys.com/amh.ca/redcap/surveys/?s=JK4X_K83AYC">https://redcapsurveys.com/amh.ca/redcap/surveys/?s=JK4X_K83AYC</a>

<b>Bounce Back</b>	Free guided self-help program that's effective in helping people who are experiencing mild- to-moderate anxiety or depression, or may be feeling low, stressed, worried, irritable or angry.	<a href="https://bouncebackontario.ca/adults-19/">https://bouncebackontario.ca/adults-19/</a>
<b>Wellness Together Canada</b>	Wellness Together Canada provides tools and resources to help Canadians. These include modules for addressing low mood, worry, substance use, social isolation and relationship issues.	<a href="https://ca.portal.gs/">https://ca.portal.gs/</a>
<b>AbilitiCBT</b>	AbilitiCBT is an internet-based cognitive behavioral therapy (iCBT) program that you can access from any device, any time.	<a href="https://ontario.abiliticbt.com/home">https://ontario.abiliticbt.com/home</a>
<b>BEACON</b>	Online CBT. BEACON includes specific support for frontline health workers.	<a href="https://info.mindbeacon.co m/btn542">https://info.mindbeacon.co m/btn542</a>

### Managing Team Members Working at Other Facilities

The management of team members working at other Homes will largely be guided by the local Public Health Unit and from government/legislated directives. The Home may restrict team member movement to not transmit the virus between Homes. During a pandemic the illness may will be widely circulating and probably affecting many Homes.

### Deploying Team Members

Team members in the Home may need to be deployed to other designated work areas in the Home, and/or may be asked to work at another Caressant Care Home. Prior to deploying team members to another location, the Home should consider:

- Individual Homes will continue to be accountable for their own teams, and ensure staffing levels are appropriate to meet Resident care needs prior to deploying anyone.
- Team members and temporary team members, volunteers will be deployed in order to ensure adequate levels of care.
- Transferable skills and delegated acts may be initiated based on the Homes' pandemic plan.

### JOHSC & Unions – Sharing Information

It is the expectation that in the event of an influenza pandemic, that the Joint Occupational Health and Safety Committees, (JOHSC) and the Union Representatives may request more frequent meetings to review potential staffing changes, PPE requirements, policy changes, team member illness/accommodation needs etc. Regular meetings and information sharing with both groups is key, some reminders for team members include:

- For physical health and wellness related concerns, team members can contact a healthcare professional by contacting **Telehealth Ontario at 1-866-797-0000**
- If team members have concerns about their health and safety that the employer is not addressing, they can file a complaint with the **Health and Safety Contact Centre at 1-877-202-0008**
- If a team member **suspects they may be ill**, they should not come to work and should notify their supervisor/delegate. The supervisor/delegate in consultation with the local PHU will confirm when the team member can return to work.
- If a team member believes they have **an illness at work**, in accordance with the Occupational Health and Safety Act, an employer must report to WSIB within 72 hours of being notified by the employee. Notification will be shared with Head Office, JOHSC, MOL and Head Office as required.

All team member requests for work accommodations should be discussed with the head office WSIB Coordinator.

## Recreation

The Recreation team plays an essential role in ensuring Resident wellbeing and morale throughout the pandemic. While most typical activities are suspended, Recreation team members can develop activities for small groups, one-on-one, and in room. The Recreation team should clear activities with Nursing and Joint Health and Safety to ensure they comply with the latest pandemic procedures and specific Resident needs.

In Room Activities	Hallway Activities	Daily Small Gestures
<ul style="list-style-type: none"> <li>• Crosswords, word search, colouring books, trivia sheets</li> <li>• Knitting, puzzles, painting, etc.; provide supplies</li> <li>• Movies, TV, music, audiobooks (can purchase portable devices to be disinfected between uses)</li> <li>• Create mini activity kits with combination of above</li> <li>• Hand out devotional reading / prayer for spiritual Residents</li> <li>• Consider online mass via TV or tablets during pandemic</li> <li>• Painting rocks to leave around Home</li> </ul>	<ul style="list-style-type: none"> <li>• Bingo</li> <li>• Adapted board games (e.g., Yahtzee with each their own dice)</li> <li>• Word games / trivia</li> <li>• Sing-a-longs</li> <li>• Live music by team member</li> <li>• Hallway meditation</li> <li>• Exercises</li> </ul>	<ul style="list-style-type: none"> <li>• Leave printed quote in room</li> <li>• Daily greeting / prayer over PA</li> <li>• Resident spa (bubbles and battery-operated candles in tub)</li> <li>• Short video from family</li> <li>• Bubbles in the garden</li> <li>• Flower on plate</li> <li>• Staff crazy hair day</li> <li>• Joke of the day</li> </ul>

#	Steps to Implement	Done
1	Review all existing activities and modify to ensure physical distancing. Only small group activities where physical distancing can be maintained should take place.	
2	<p>Prepare activities for Residents in their rooms or practicing physical distancing. This can include developing an “in room” calendar for recreation. Examples include:</p> <ul style="list-style-type: none"> <li>• Hallway / doorway bingo, fitness classes, etc.</li> <li>• Individual activities such as puzzles, art / painting in room, coloring, crosswords, etc.</li> <li>• Postcard/letter writing to family, friends or other Residents</li> <li>• Play soft noise music</li> <li>• Small group outings to garden areas (with physical distancing)</li> <li>• Install bird feeders to provide outside visuals</li> <li>• One on one activities with recreation staff</li> <li>• Encourage families to provide gifts such as plants, books, smart devices for calls, etc.</li> </ul> <p>For additional individual activities, see resources above. Activities should be tailored to individuals’ preference while maintaining safety of staff and Residents a priority.</p>	
3	Ensure all materials used in recreation are adequately sanitized.	
4	Schedule virtual calls with families on a regular basis.	

5	Organize outside/window visits from families. Other outside events that allow Residents to remain in isolation can include outside/window concerts.	
6	If possible, capture photos / videos of Residents to share with family Note: Prior consent from Resident and family may be required, and staff should not use their personal device to record images of Residents.	
7	Work with HR to support team morale.	
8	Continue with all activities listed in the prevention section unless otherwise indicated below.	
9	When there is a suspect or known case, cease all group activities, only in-room individual Recreation.	

## Pharmacy Medication Management & Antiviral Distribution

The availability of medications, on-site pharmacy resource personnel and antivirals may result in changes to the management of the medication program in the Homes. The DOC/DHW/designate should engage in discussions with the pharmacy provider to consider implementation of the following: (note list is not all inclusive):

- Virtual drug destruction
- Individual Resident Medication Compression
- Virtual Clinical Pharmacists Visits
- Narcotics Reallocation

### Antivirals

Antiviral and vaccine medications (if/when available) will be distributed according to government directives.

- The local Public Health Unit may be responsible for the release of a vaccine to health care facilities and agencies that can administer the vaccine to the Residents, clients and their own employees
- The Medical Directives for the administration of antiviral and vaccine medications and the administration of epinephrine, if needed due to adverse reaction, will be obtained from the Medical Officer of Health or Medical Director through the facility Pharmacy provider
- The Infection Control Lead/delegate will maintain a list of:
  - Vaccinated and non-vaccinated team members
  - Team members that received and refused antivirals
  - Vaccinated and unvaccinated Residents
  - Residents that received and refused antiviral
  - Consents for both team members and Residents

### Antiviral Storage/Tracking

If antiviral medication is available and distributed to Homes for administration, there may be strict guidelines from the local PHU or government on the storage and tracking requirements. Homes may need to ensure that at a minimum the following are in place:

- Each Home must ensure they have a designated cold chain storage location monitored by a temperature log to ensure viability of vaccine
- The vaccine fridge must maintain temperatures in the range of 2-8 degrees Celsius
- The vaccine fridge temperatures will be monitored twice daily by the DOC or designate
- The vaccine fridge should be connected to an emergency outlet to avoid Cold Chain failure in the event of a power outage.

## Media & Communication

It is critical that messaging is consistent during uncertain times, and so the Home requires that no team members communicate with the press. All requests should be redirected to the head office and [info@caessantcare.com](mailto:info@caessantcare.com)

All team members should be wary of misinformation in rapidly evolving situations of a pandemic. Team members should always refer to the most up-to-date information from official sources such as the Ministry of Health and Public Health Ontario.

In addition, some Homes may receive phone calls from people claiming to be Public Health or Ministry officials. If a call seems suspect, especially if specific team member or Resident information is requested, team members should:

- Not share any information (e.g., “This is not my area, but I’d be happy to get the appropriate person to call you back.”)
- Get the individual’s name and contact details
- Mention the appropriate person will call them back
- Verify the contact with authorities to confirm validity

### Communications – Internal

- The Director of Care – will provide a status report about pandemic activity in the Home on a daily basis
- Each Home will determine the location of an **Emergency Command Centre**. This Centre will be equipped with teleconference abilities and computer network access
- The Outbreak team will meet daily and as needed in the Command Centre. The team has the overall responsibility for overseeing, directing, and ensuring that outbreak practices & procedures are initiated and communicated to all team members.
- Minutes of the team meetings will be posted at each nursing station & on the Infection Control Board.
- The DOC/Leadership will communicate pandemic information and updates obtained at the team meeting to their team members via the following:
  - Huddles on the units/unit meetings
  - Postage signage at entry/exit
  - Handouts/Fact Sheets
  - Team meetings including JHSC Meeting
  - Posted information on the OH & S Board, Infection Control Board
  - Placing information in the Pandemic Information Binder for Staff

### Communications – External

- All general inquiries regarding the pandemic should be directed to the local Public Health Unit.
- The media spoke person for Caessant Care is the Head Office Woodstock. They shall be responsible for providing all information to the news media.
- Each facility may wish to survey their family members and volunteers in regard to their ability to volunteer to assist during a pandemic (i.e., screener).
- The Registered Staff on each unit is responsible for contacting and responding to family’s questions & concerns.
- Information about the pandemic and the homes actions will be shared with Resident, Families, Volunteers, and Visitors via the following:
  - Fact sheets/handouts

- Signage posted on entry/exit
- Newsletter
- Formal Letters from the Home/Corporation
- Social Media (Facebook, corporate website)
- One-Call
- Virtually – e.g., Zoom, Virtual Care, Microsoft teams

## Emergency Supplies/Stockpiling Plans

During a Pandemic, Health Care Facilities will need large quantities of both equipment and supplies to provide care and to protect their workers. Demand for these items will be high worldwide and normal supply chains may break down. In preparing for a pandemic, the following measures should be initiated:

### Important to Know

Preparing for and responding to an outbreak requires critical supplies outlined in the below section.

- The Home should determine its par supply (daily usage) and use a risk factor to calculate minimum quantities to have on hand; consider increased usage when calculating this (e.g., more frequent cleaning)
- In addition, supplies for which demand will surge once there are positive cases should be identified and minimum quantities account for this (e.g., disposable cutlery)
- As pandemics often create supply shortages in critical supplies such as PPE, Homes should communicate with suppliers frequently to understand the situation, and potentially order further ahead of time
- Alternate suppliers for critical supplies should be identified
- Authorities may require reporting of inventory on hand for critical supplies (PPE, ABHR, etc.) – ensure processes are in place

If Homes are struggling to secure supplies from their contracted provider, they should reach out to their Regional Director of Operations who along with the Corporate Office will endeavor to secure supplies from other sources.

- The Corporate Office will maintain a small stockpile of critical supplies along with a list of alternative suppliers.
- Homes should maintain a minimum of a 7-day pandemic supply, a 7-day stockpile of non-perishable food items, and will maintain 24 hours' worth of potable water for Residents & team members.
- All supplies are to be checked for expiration dates and rotated on a regular basis to prevent stock expiration. The ED and FNM will determine the frequency of the stock rotation.

## Essential Supplies

Category	Supplies	Done
PPE	Surgical Masks	
	N95 respirators	
	Gloves (all sizes)	
	Gowns – reusable and disposable (all sizes)	
	Face shields – reusable and disposable	
	Goggles – reusable and disposable	

## Dining Supplies

Category	Supplies	Done
In-Room Dining Supplies	Individual tables	
	Paper / disposable plates, cups and cutlery	
	Trays	
	Additional carts to allow use of separate equipment for each floor / unit	
	Additional containers	
Food Supplies	Pandemic menu	
	Thickeners	
	Supplements, baby food (pureed meals)	

## Other

Category	Supplies	Done
Other	Shrouds/Body Bags	
	Thermometers and scan cover	
	Hand Sanitizer	
	Garbage cans (that don't require hand touch to open)	
	Oximeter machines	
	Disposable Wipes/ Disinfectant Wipes	

## See Appendix – Supplies & Equipment Checklist Template

### 8. Implement Controls for Visitors

#### Visitor Management

As with any outbreak visitor restrictions are likely to be out in place and may be directed/mandated by legislative bodies. The restriction of visitors may be a necessary requirement during the pandemic to prevent the spread of the virus/contagion to our most vulnerable population. Homes should expect that only essential visitors (those who regularly provide hands on care to Residents, or provide essential services i.e., food delivery) and visitors visiting ill or palliative Residents may be the only visitors permitted entry to the Home.

#	Steps to Implement	Done
1	<p>Only <b>essential visitors</b> should be allowed to enter, defined as:</p> <ul style="list-style-type: none"> <li>Performing essential support services (e.g., food delivery, phlebotomy, maintenance, family or volunteers providing care services and other health care services required to maintain good health); OR</li> <li>Visiting a very ill or palliative Resident; these visitors must visit only the one Resident and no other Resident.</li> </ul>	

2	<p>Visitors must be screened at entry (<b>apart from Emergency responders</b>).</p> <ul style="list-style-type: none"> <li>• If the essential visitor fails screening, refuses to answer the questions, they will not be allowed to enter the Home.</li> <li>• The screener should inform them to go Home and self-isolate and contact local public health unit or telehealth for further instruction.</li> <li>• If any visitor becomes upset or has further questions, staff should contact a manager or delegate to handle the situation.</li> </ul>	
3	<p>Essential visitors must:</p> <ul style="list-style-type: none"> <li>• Only visit the Resident they are intending to visit and no other</li> <li>• Wear a mask at all times, unless otherwise directed (as per Ministry guidelines)</li> <li>• Practice physical distancing (if required)</li> <li>• Wear appropriate PPE if visiting a Resident suspected or infected with pandemic contagion</li> </ul> <p>*Note: Best practice indicates to have all visitors wear PPE when entering the Home so as to minimize risk of infection, if possible.</p>	
4	<p>Staff must support the essential visitor in appropriate use of PPE:</p> <ul style="list-style-type: none"> <li>• Demonstration of putting on and taking off PPE safely, as needed</li> <li>• Hand hygiene</li> </ul>	
5	<p>If possible, consider dedicating one room isolated in the community that is set up for visits and disinfected after each visit.</p>	
6	<p>Discontinue all non-essential activities (e.g., pet visitation programs, any outside group).</p>	
7	<p>Facilitate other methods of keeping in touch with Residents, including families and specialists, through supporting Residents with video calls and phone calls.</p>	

## 9. Mass Fatality Management

### End of Life Care

The Office of the Chief Coroner may provide direction to Homes on the management of deceased Residents during a pandemic.

### Death Pronouncement

According to the College of Nurses, the practice standard states a nurse may pronounce death in situations of expected death, meaning the resident is terminally ill and there is no available treatment to restore health or the client refuses the available treatment. Pronouncing death is to *declare death has occurred*.

In a pandemic outbreak it may be anticipated that a RN and RPN will pronounce death. This practice may need to be altered in the pandemic situation.

### Faith Practices

During a pandemic the Office of the Chief Coroner will likely provide direction on the ability to allow for faith practices upon the death of a resident. If permitted, faith practices outlined by the Resident/SDM prior to death will be adhered to. If the family is not available, local religious and ethnic communities will be consulted for information and guidance.

### Visitors at End of Life

Visitors may be allowed into the Home for Residents that are nearing the end of life.



#	Steps to Implement	Done
1	Coordinate <b>family visit</b> provided they can follow safety procedures for visiting: <ul style="list-style-type: none"> <li>• Screening prior to entry</li> <li>• One visitor at a time</li> <li>• Follow PPE protocols</li> <li>• Maintain physical distancing from Resident’s roommate</li> <li>• Adhere to hand hygiene protocols</li> </ul>	
2	Instruct visitors to maintain physically distant from other Residents and individuals in the home.	
3	If family cannot visit (e.g., at-risk individual, failed screening, many people, etc.), schedule a <b>video call</b> with the Resident.	

### Safekeeping of Resident Deceased Personal Belongings

Because of limited storage space in most Homes, it is expected that the Residents POA or family members will be contacted to remove the personal belongings within 24 hours following the death of a Resident. The following will be shared with the POA/family member:

- Verbal consent will be acquired by the POA/family member to box up the belongings as visitor restrictions may be in place.
- The facilities will follow directions from the families re: dispersal of personal belongings and/or donations.
- 2 team members will pack the Resident’s belongings while creating an inventory of items packed and will sign off on the list – verifying the contents. A copy will be provided to the POA/family member, and a copy retained by the Home.
- The families will be advised of the need to pick up belongings as soon as possible.

### 10. When the Outbreak is Over

#	Steps to Implement	Done
1	In collaboration with local PHU, outbreak may be declared over when there are no new cases in staff after <b>___days from the latest of:</b> <ul style="list-style-type: none"> <li>• Date of isolation of last Resident case</li> <li>• Date of illness onset of last Resident case</li> <li>• Date of last shift at work for last team member case</li> </ul>	
2	<b>Remove outbreak signage</b>	
3	<b>Outbreak end communication</b> protocols should be initiated, and Prevention communications may resume until the pandemic is declared over.	
4	Schedule time with key team members to review outbreak management and capture <b>lessons learned</b> . Update relevant documentation.	

## Outbreak End Communication

- |  |   |
|--|---|
| <input type="checkbox"/> Home Management                               | <input type="checkbox"/> Home Line Listing: Resident                      |
| <input type="checkbox"/> Outbreak Management Team (OMT)                | <input type="checkbox"/> Home Line Listing: Employee                      |
| <input type="checkbox"/> Infection Control Lead                        | <input type="checkbox"/> Remove Outbreak signage (Room / Unit / Building) |
| <input type="checkbox"/> Joint Health & Safety Committee               | <input type="checkbox"/> Pharmacy   |
| <input type="checkbox"/> All affected residents and families           | <input type="checkbox"/> Laboratory                                       |
| <input type="checkbox"/> All non-affected residents and families       | <input type="checkbox"/> Suppliers / contractors                          |
| <input type="checkbox"/> All home employees                            | <input type="checkbox"/> Agency support (if applicable)                   |
| <input type="checkbox"/> Regional Leaders / HQ / Board (if applicable) | <input type="checkbox"/> Volunteers                                       |
| <input type="checkbox"/> Home Medical Director / Physician             |   |
- 
- |   |   |
|---|---|
| <input type="checkbox"/> Local Public Health                        | <input type="checkbox"/> LHIN   |
| <input type="checkbox"/> Municipal / City Authorities               | <input type="checkbox"/> Union(s) representatives                     |
| <input type="checkbox"/> Director for the LTC Ministry / MOH        | <input type="checkbox"/> Ministry of Labour (if employee(s) affected) |
| <input type="checkbox"/> Hospital Emergency Department / Paramedics |   |

## 11. Investigate & Review the Outbreak

### Outbreak Management Meeting

At the meeting review the following:

1. **Investigate the Outbreak** – An investigation file should be created to review the following:
  - a. Copies of laboratory and other pertinent results
  - b. Copies of all meetings minutes & pertinent communication
  - c. Any other documentation specific to the investigation
  
2. **Review the Pandemic Outbreak**
  - a. Meet with local public health unit & community partners to review what all happened:
    - i. What was done well?
    - ii. What hurdles did the Home face?
    - iii. What lessons were learned?
    - iv. What documents/checklist or policies may need to be revised?
  - b. Submit the report to the infection control committee with a copy to the Home's Executive Director for filing.

# Appendices

### Job Tasks – COVID-19 Door Screener

1. Upon entering work area – **Sanitize your hands**
2. Don (put on) Personal Protective Equipment (PPE) in proper order unless behind plexiglass; in which case you require a mask only: (a) gown (b) mask (c) shield (d) gloves
3. Prepare Station – **Disinfect** - Look to see you have all your supplies in adequate amounts
  - a) Visitor Screeners – make sure you have enough sheets printed in case electronic screener is down.
  - b) Sanitized pens
  - c) Sanitized thermometer
  - d) Hand Sanitizer
  - e) Disinfectant Wipes
  - f) Masks – gowns – gloves
  - g) Garbage can
4. As Team Members/Visitors enter – **ensure Social Distancing** – 6 ft minimum – if screening in a confined area – only one person allowed in at a time.
5. Before Screening starts – have **Team Member/Visitor**: Sanitize Hands, put on mask, visitors to put on additional PPE if require
6. Take Temperature (if required by MOH directives)
7. Ask Team Member/Visitor Screening Questions and hand out visitor policy and IPAC documents to visitors
8. **Sanitize pen between each use or have “clean” and “dirty” containers for pens.**
9. Allow staff/visitor to enter Home area if they have passed screening
10. If there is a requirement (from MLTC/RHRA/PHU) for team members/visitors to be screened when leaving for the day:
  - a) ask screening questions
  - b) take temperature
  - c) screener to complete staff log sheet/visitor screening tool
  - d) staff/visitor can remove mask and dispose
  - e) staff/visitor to sanitize hands

**\*\*Remember to WIPE PEN between uses\*\***

**NOTE:** During your shift – you are to be consistently wiping your area – includes door handles, automatic door buttons, furniture and any other high touch areas. If tasks are complete and no team members/visitors are presenting themselves – please see Supervisor for alternate tasks.

If a delivery is made – package is to be wiped down (if required) and if necessary - bagged according to home policy before entering the Home Area. **NEVER LEAVE** screening station unattended unless entrance is locked.

11. At your shift end:
  - a) Restock supplies for the next shift
  - b) Doff (take off) PPE: 1) Remove gloves – dispose, 2) Remove gown – dispose 3) Perform Hand Hygiene, 4) Remove Shield (keep for own future use), 5) Remove Mask – dispose, 6) Perform Hand Hygiene

**Ensure Entrance is Locked.**

### COVID-19 Screener Audit

Facility: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Auditor: \_\_\_\_\_

Name of Screener: \_\_\_\_\_

1. There is a screener present at the entrance to **actively** screen all HCWs, other staff, and visitors (indoor, essential, non-essential, etc.) as they enter the building?  
YES                      NO                      N/A
2. Active screening procedure occurs 24 hours a day, seven days a week?  
YES                      NO                      N/A
3. Hand Hygiene completed by each individual upon entry to home?  
YES                      NO                      N/A
4. Screening questions are read out loud by the screener to each individual who wishes to enter the building (i.e. the individual should not be doing this passively)?  
YES                      NO                      N/A
5. Staff and visitors (indoor and outdoors) are screened daily?  
YES                      NO                      N/A
6. There is a process to record who has entered and exited the home?  
YES                      NO                      N/A
7. There is a process to identify type of visitor and record of their name, contact info, resident they are visiting and in/out time?  
YES                      NO                      N/A
8. The screener is wearing a mask, eye protection, gown and gloves OR is behind a plexiglass partition (where a mask only is required)?  
YES                      NO                      N/A
9. There is hand sanitizer with 70-90% alcohol concentration at the screener table/entrance?  
YES                      NO                      N/A
10. All staff and visitors perform hand hygiene prior to putting mask on?  
YES                      NO                      N/A
11. Masks are available to staff and visitors at the entrance for donning upon entry to the home?  
YES                      NO                      N/A
12. PPE (masks, eye protection, gowns, gloves) available for staff or visitors who require full PPE?  
YES                      NO                      N/A
13. Signage/posters present for how to don and doff PPE, proper hand hygiene, etc.?  
YES                      NO                      N/A
14. Is physical distancing taking place and is there signage promoting physical distancing?  
YES                      NO                      N/A
15. PPE doffing station available at the screener table (for screener or visitors who need to wear the full PPE)?  
YES                      NO                      N/A

**Results:** *If "Yes" to all questions, circle compliant. If any answers were "No", circle Non-Compliant.*

**Compliant**

**Non-Compliant**

**Action Plan:** *If non-compliant – record what action was completed in order to ensure compliance.*

## The Person Behind the Mask

### Communicating with Clients Living with Dementia in Long Term Care While Protecting Ourselves

#### Let's Remember:

Due to the ongoing concerns related to COVID-19, Residents with dementia may experience increased anxiety and/or confusion while they're in quarantine. Residents are currently isolated from family, friends and loved ones due to current visiting restrictions which may be impacting their mental health and ability to socialize with others. In addition, for the safety of both Residents and health care workers, the use of Personal Protective Equipment (Such as Masks) may limit or hinder the ability for Residents to connect with their health care workers. Existing behavioural and psychological symptoms may be heightened, and these Residents may be at a greater risk of developing new or progressing Responsive Behaviours and/or Delirium.

#### Barriers to Communication:

- The Resident is unable to read facial expressions.
- The Resident is unable to see your mouth as you form words.
- The Resident may hear a muted/muffled version of what you are trying to say and may misinterpret your words.
- The Resident may be unaware that you are trying to communicate with them.
- The Resident may not understand why you are wearing a mask.
- Wearing a mask may evoke fear in the Resident.

#### Strategies to Improve Communication:

Approach from the front and ensure the Resident sees you.

Make eye contact so the Resident knows you are talking to them (Remember any cultural considerations regarding eye contact).

- Use touch (shoulder or hand), if appropriate (personal preference/cultural preference).
- Use clear, short and simple sentences.
- Be aware of the tone of your voice, when speaking.
- Continue to use the Resident's preferred name.
- Continue to ask permission before engaging in any tasks.
- If the Resident has hearing loss, speak on their dominant side or on the side they are wearing their hearing aid(s).
- Allow the Resident more time to process what is being said (remember, this may take approximately 30-40secs).
- Consider using a white board to communicate information.
- Consider using communication cards with words/pictures of any tasks.
- Consider using appropriate non-verbal cues including gestures demonstrating what you are asking of the Resident (i.e., helping the person to dress or bringing them a meal).
- If the Resident has questions surrounding precautions or PPE, provide simplified explanations.
- If communication is not going well for you or the Resident, stop what you are doing (as long as the individual is not at risk) and re approach at another time when you/the individual have de-escalated
- Even though you are wearing a mask, continue to smile as this may change your tone.

*BSO Psychogeriatric Resource Consultant (PRC) Team, April 2020 (Adapted from Caitlin Reidy, BSO BIS)*

#### Reminder for Self-Care:

Many staff are likely dealing with increased workloads and/or added stress both in the workplace & at home. It is important for Staff to look after their own Physical & Mental Health during these times.

**Thank you for all that you do!**

## Donning & Doffing PPE

PUTTING ON PERSONAL PROTECTIVE EQUIPMENT		
<b>1</b>	PERFORM HAND HYGIENE	
<b>2</b>	PUT ON GOWN	
<b>3</b>	PUT ON MASK OR N95 RESPIRATOR	
<b>4</b>	PUT ON EYE PROTECTION	
<b>5</b>	PUT ON GLOVES	

REMOVING PERSONAL PROTECTIVE EQUIPMENT		
<b>1</b>	REMOVE GLOVES	
<b>2</b>	REMOVE GOWN	
<b>3</b>	PERFORM HAND HYGIENE	
<b>4</b>	REMOVE EYE PROTECTION	
<b>5</b>	REMOVE MASK OR N95 RESPIRATOR	
<b>6</b>	PERFORM HAND HYGIENE	

## Supplies and Equipment Checklist Template

<b>Supplies and Equipment</b>		
<b>Category</b>	<b>Item</b>	<b>#</b>
<b>Hand Hygiene</b>	Liquid Soap	
	Alcohol Hand Rinse/Sanitizer	
	Paper Towels	
<b>Personal Protection Equipment</b>	Surgical/Procedure Masks	
	N95 Masks	
	Paper gowns (small, medium, large, XL, XXL)	
	Latex Exam Gloves (small, medium, large, XL, XXL)	
	Non-latex gloves (small, medium, large, XL, XXL)	
	Safety Glasses/Protective shields	
	Paper bags to store masks	
<b>Temperature &amp; BP Monitoring Supplies</b>	Thermometers (disposable covers) -Infrared	
	Stethoscopes	
	BP cuffs (Child, Adult, Large adult sizes)	
	Oximetry Machines	
<b>Disinfectants</b>	Disinfecting Wipes	
	Surface cleaner and disinfectant	
<b>Cleaning</b>	Garbage bags – clear 20x20 for individual stations	
	Garbage bags	
	Autoclave and other specialized waste disposal bags	
	One-use tissues	
	Garbage Cans with step touch opening	
<b>Respiratory Care</b>	Oxygen tubing	
	Oxygen masks – high concentration masks (non-rebreathers)	
	Nasal prongs/cannula	
	Oxygen masks – low concentration (simple O2 masks, venture masks)	
	Portable oxygen tanks with regulators	
<b>Suction</b>	Disposable tips, catheters, tubing, canisters	
	Disposable manual resuscitators (BVM) & filters (various sizes)	
	Inline suction catheters	
	Portable suction	
<b>Paper Products</b>	Paper cups	
	Paper absorbent table cover	
	Paper plates	
	Paper bowls	
<b>Cots/Mats</b>		
<b>IV Products</b>	Solutions	
	Tubing	
<b>Deceased Body Management</b>	Body Bags/Shrouds	
<b>Incontinence</b>	Briefs, pads, wipes	



## Home Preparedness Checklist

Task	Yes/No	Action	Date Completed
<b>Planning</b>			
There is a person designated to lead the pandemic team/planning committee?			
Have community partners been identified and then contacted?			
Community partners have met with the facility and pandemic plans discussed			
Has the facility identified strategies for surge death management?			
Are there plans in place to ensure continuity of services in the event of internal emergencies – water, hydro, food, etc.?			
<b>Chain of Command</b>			
Who is on the Outbreak Management Team & what are their roles & responsibilities?			
What is the chain of command for initiating the pandemic plan?			
Is there an infection control designate?			
Roles & responsibilities during a pandemic have been reviewed & discussed with staff.			
Where will the command centre be located?			
<b>Occupational Health &amp; Safety</b>			
Training on PPE has been conducted with all staff			
Fit mask testing has been conducted on all staff			
<b>Communications</b>			
Is there a system in place for communicating with staff, Residents, families etc. during a pandemic?			
Where will updates of pending pandemic issues be posted in the facility?			
Have alternative forms of communication been determined if main method is not available?			
There is a system & person responsible for handling all media requests and it is known to staff			
The facility has determined the types and numbers of signage's needed for directing people to screening areas, closed areas etc.			
<b>Human Resources</b>			
The facility has identified the skills that staff etc. can provide if needed			
There is a contingency plan for if > 25-35% of staff are ill during peak pandemic period			
Is there a facility work refusal policy?			
What resources have been identified for outside staffing assistance for all depts.?			
How will credentialing of outside resources be handled?			
Have possible modified /changed roles been reviewed & discussed with bargaining units			
What training will outside agencies, volunteers are given if needed in facility? Job action sheets?			

Task	Yes/No	Action	Date Completed
Has staff received education and training on pandemic issues?			
Have staff support systems been discussed i.e., child care, transportation, meals etc.			
<b>Education &amp; Training</b>			
Who will conduct any required training?			
Are there shortened versions of orientation, job routines etc. available for role changes?			
Outbreak education has been reviewed with all staff – i.e., what signals an outbreak			
<b>Resident Care</b>			
Residents who could be cared for in other settings have been identified			
Services that could be maintained or enhanced have been identified			
Services that could be reduced or eliminated have been identified			
Resident essential care needs are current on care plans			
High risk Residents that only nursing staff should care for have been identified			
<b>Anti-virals / Vaccines</b>			
Does the facility have adequate capacity to store anti-virals & vaccines			
Have Residents who are to receive anti-virals been identified?			
Which Residents are to receive vaccines?			
Are resident medical directives and consents current to allow rapid administration of meds?			
Is there a plan for screening of staff & visitors?			
The facility is aware of required reporting forms and has sufficient quantities readily available to staff for i.e., Public Health etc.			
<b>Support for Visitors/Families/Volunteers</b>			
How will the facility handle increased numbers of visitors wanting entrance to the facility or who want to remove Residents from the Home?			
Who will handle family concerns?			
<b>Supplies</b>			
Has a list of supplies been identified for resident care, environmental, etc. x 1 month			
Have suppliers been contacted re abilities to supply items during a pandemic?			
Can local suppliers provide medical equipment if needed?			
Have back-up suppliers been identified?			
Has the facility pharmacy provider been contacted to review facilities needs?			
Are there relationships with other facilities to coordinate stockpiling with?			
<b>Security</b>			
There is a lock down system in place for controlled entrance & existing of building			
Lock down system has been tested			

Task	Yes/No	Action	Date Completed
Is there an alternative system available besides facility lockdown to secure access points?			
What system is in place for meeting & escorting emergency service personnel?			
<b>High Mortality</b>			
Where will deceased belongings be kept?			
Have off-site morgue capacities been reviewed as to capacity and location?			
<b>Relocation of Residents</b>			
Has the physical layout of the facility been reviewed to identify natural isolation areas for Residents if such an area and move is needed?			
Is there a temporary location identified in case evacuation of the facility is required?			
Have area facilities met to discuss the possible relocation of their Residents to other facilities?			
Has a meeting occurred with local Hospital re: either transfer of Residents to the Hospital or to receive patients from the Hospital?			
How will Residents be moved to temporary locations?			

## Initial Pandemic Outbreak Meeting Template

**1. Pandemic Outbreak Committee Members:**

Position	Committee Member Name
Executive Director	
Medical Advisor/Attending Physician. NP	
Director of Care / ADOC/ RN	
Infection Control Lead	
Food and Nutrition Manager/ Dietary	
Health and Safety Worker Co-Chair	
Environmental Services Manager	
Recreation Manager	
Pharmacy Consultant	
Physiotherapy Services	
Staff Representatives	
Union Representative	
Public Health Representative	
Emergency Planning Officer	

**2. Chairperson:** responsible for coordinating team meetings & delegating tasks:

Primary: \_\_\_\_\_

Alternate: \_\_\_\_\_

**3. Recording Secretary:** responsible for meeting minute taking and distribution:

Primary: \_\_\_\_\_

Alternative: \_\_\_\_\_

**4. Outbreak Coordinator:** responsible for ensuring all committee decisions are carried out. Coordinates all activities required to investigate and manage outbreak

Primary: \_\_\_\_\_

Alternate: \_\_\_\_\_

**5. Media Spokesperson:** responsible for responding verbally or in writing to all Media Inquiries:

Primary: Caressant Care Communications Manager/ Local Public Health Unit

Alternative: \_\_\_\_\_

**6. Person Responsible for anti-viral:** \_\_\_\_\_

Alternate person: \_\_\_\_\_

Anti-virals stored: \_\_\_\_\_

Alternate antiviral location: \_\_\_\_\_

7. **Command Centre location:** \_\_\_\_\_

8. **Main pandemic bulletin board location:** \_\_\_\_\_

9. **Shortened job action sheets for each dept. located:** \_\_\_\_\_

10. **Screening Location & Documents:** \_\_\_\_\_

11. **Infection control surveillance forms binder location:** \_\_\_\_\_

12. **Meeting Agenda:**

Agenda Item	Person Responsible
Case Definition:	
Signage – What is needed and where to post?	
Specimen Collection – How, what Residents, when, and how often?	
Communication Plan: - Internal - External	
Staff Education/ Training – Any needed?	
Daily Communication with PHU: Line list updated, time to call	
Review of required PPE/Control Measures – Type, where set up	
Frequency & Time of Outbreak Meetings:	
Other:	

### Daily High Touch Cleaning Checklist

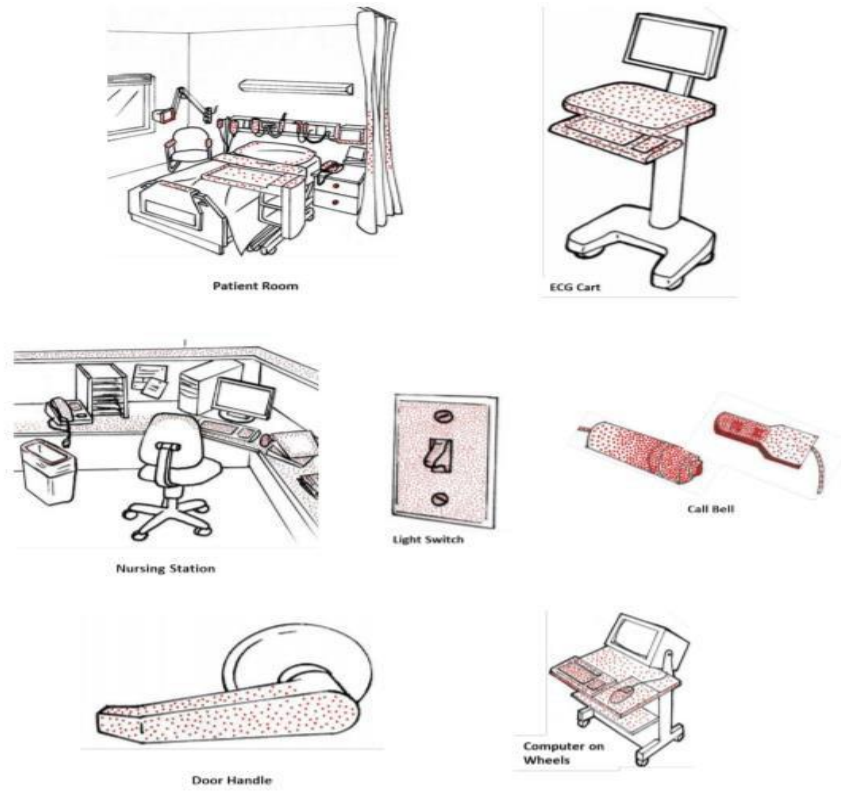
High Touch Surfaces – are surfaces that are handled frequently throughout the day by numerous people.

*Environmental Services – Disinfect the following area twice daily:*

Area	Yes	No	Comments/Reason Not Completed
Door Knobs			
Elevator Buttons (if applicable)			
Hallway Railings			
Reception/Screening Station/Area			
Wall Mounted and/or Stand-up Hand Hygiene Receptacles			
Walkie Talkies and/or Communication Devices (if applicable)			May be assigned to nursing
Activity Chairs/Arms if applicable (used in a program)			
Dining Chairs & Arms			
Light Switches			
Bathroom Faucets			
Toilet Flush Handles			
Wall Area around Toilet			
Remote Controls – TV and/Lift Device Remotes			
Call Bells			
Bed Rails			
Phones			
Overbed Tables			
Beside Stands: Top and Drawer Handles			
Medical Equipment			May be assigned to nursing
Computer Keyboards, Lap tops, POC Terminals, IPODS, IPADS			May be assigned to nursing
Screening Desk/Area			

## Examples of High Touch Items & Surfaces

*Note – Resident w/c, walkers, lifts and PASD's should be cleaned as per schedule by nursing staff*



**Figure 3a: Examples of High-Touch Items and Surfaces in the Health Care Environment**  
(Note: Dots indicate areas of highest contamination and touch)

**Caressant Care Occupational Illness/ COVID-19 Outbreak Tracking Form**

Date:

Home:

Type of O/B:

Public Health Outbreak#

MOL Notified: Y  N

<b>Employees Name</b>	<b>Date of Illness (last day worked, cannot be the same as the first day lost)</b>	<b>First Day Lost</b>	<b>How Many Scheduled Hours was the Lost Shift? (i.e.: 7.5)</b>	<b>How Many Shifts Lost?</b>	<b>Date Employee Returned to Full Duties</b>



**Cross Trained Staff**

Staff Name	Current Department	Housekeeping	Laundry	Dietary	PSW	Feed Assist	Supplies Ordering	Scheduling/WC	Registered Staff	Advanced Wound Care	Medication Administration

### Laundry Audit

FACILITY:			DATE:	
ITEM	MET	UNMET	COMMENTS	
Are carts arriving with soiled linen bags covered and bags tied off?				
Is laundry sorted on carts properly? Linens, Personal Clothing, Incontinent Products				
Is clean & dirty linen kept separated?				
Are procedures for handling isolation linen posted?				
Is there protective equipment available for staff? Gowns, Gloves, Goggles/Shield				
Is PPE worn correctly? Soiled Linen Area: Long sleeve gown, Fluid Resistant Gloves & Apron, Goggles/Shield				
Is PPE worn correctly? Clean Linen Area: Long sleeve gown, Disposable Gloves				
Is soiled laundry held away from the body while carrying?				
Are hand washing signs posted?				
Are staff aware of the procedure for the safe handling of soiled linens?				
Are there designated clean linen carts?				
Are the clean linen carts covered?				
Are laundry bins marked – “clean” & “soiled”?				
Is washable PPE laundered after each use?				
Are washing machines cleaned as per procedure?				
<b>TOTAL</b>				

**Total (Met)**

**Total (Met/Unmet)**

x 100 = \_\_\_\_\_ %

## 4 Moments for Hand Hygiene

# Your 4 Moments for Hand Hygiene



<b>1</b> BEFORE initial patient/patient environment contact	<p><b>WHEN?</b> Clean your hands when entering the patient's environment:</p> <ul style="list-style-type: none"> <li>• before touching patient or</li> <li>• before touching any object or furniture</li> </ul> <p><b>WHY?</b> To protect the patient/patient environment from harmful germs carried on your hands</p>
<b>2</b> BEFORE aseptic procedure	<p><b>WHEN?</b> Clean your hands immediately before any aseptic procedure; for instance: changing a dressing, oral care, drawing blood, administering IV medication</p> <p><b>WHY?</b> To protect the patient against harmful germs, including the patient's own germs, entering his or her body</p>
<b>3</b> AFTER body fluid exposure risk	<p><b>WHEN?</b> Clean your hands immediately after an exposure risk to body fluids (and after glove removal)</p> <p><b>WHY?</b> To protect yourself and the health care environment from harmful patient germs</p>
<b>4</b> AFTER patient/patient environment contact	<p><b>WHEN?</b> Clean your hands when leaving the patient's environment:</p> <ul style="list-style-type: none"> <li>• after touching patient or</li> <li>• after touching any object or furniture</li> </ul> <p><b>WHY?</b> To protect yourself and the next patient from harmful patient germs</p>

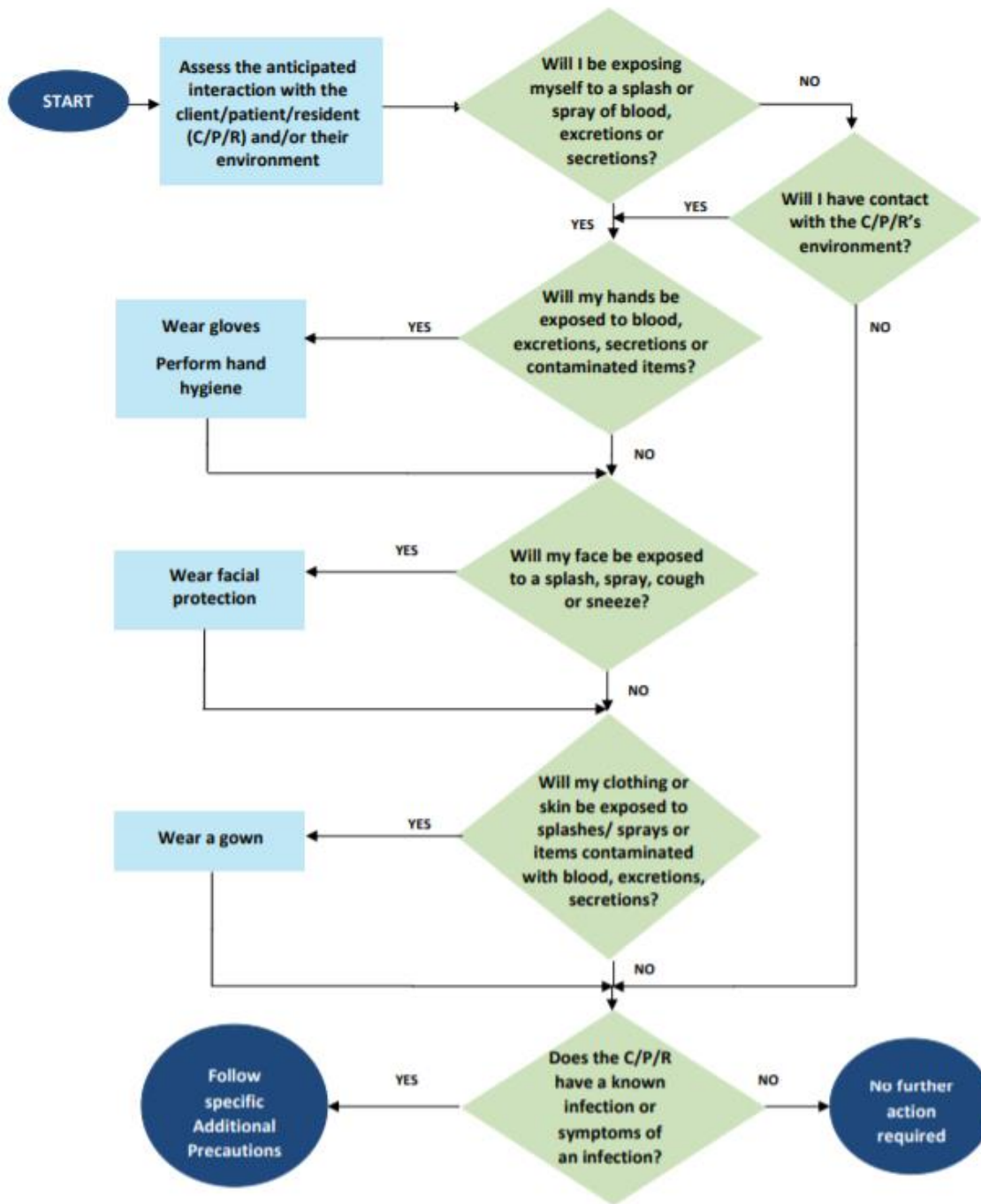
Adapted from WHO poster "Your 5 moments for Hand Hygiene," 2006.

[publichealthontario.ca/JCYH](http://publichealthontario.ca/JCYH)



Change: No. 00025 - E.M. - March 2011. © Queen's Printer for Ontario 2011.

Routine Practices Risk Assessment Algorithm for All Client/Patient/Resident Interactions



## STANDARD OPERATING PROCEDURES FOR COVID-19 OUTBREAK MANAGEMENT

This guideline outlines **standard operating procedures** to support LTC Homes with preparedness planning, case identification, and implementation of their outbreak plan, to prevent and manage an outbreak, and aligns with Directive #3 for Long-Term Care Homes under the *Long-Term Care Homes Act, 2007* and the MLTC COVID-19 Guidance Document.

This guide is not intended to replace formal Ministry, public health or other relevant direction, guidance, or statutory requirements.

### **Being Prepared\*** – Assumptions for LTC Homes Prior to the Outbreak

- Ready-to-implement Outbreak Management Plans (e.g., staffing contingency plan, including surge capacity)
- Proactive ongoing screening and monitoring of residents, staff, and visitors including essential caregivers as per Chief Medical Officer of Health Directive #3, and/or local public health unit direction to identify COVID-19 RISK\*\*
- Robust training and auditing on IPAC protocols, including cohort contingency planning, and access to personal protective equipment
- Established communication systems with families and local partners
- Vigilant resident monitoring by the medical director, physicians/nurse practitioners, and staff for early identification of COVID-19 signs/symptoms
- Established partnerships at the local level (hospital, Ontario Health Region, public health, and ministry)
- Readiness that if ONE resident/staff is identified with COVID-19 RISK\*\*, Outbreak Management Standard Operating Procedures are initiated

\* See Appendix A for a list of statutory outbreak prevention and control actions required by LTC homes.

\*\* Residents, staff, and all entrants to a LTC home experiencing signs/symptoms or potential exposure to suspected/confirmed cases.

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
0.	Outbreak Planning and Preparation	On-going	<ul style="list-style-type: none"> <li>Outbreak Management Plan, developed in collaboration with Public Health Unit (PHU), ready to implement (includes staffing contingency plan, resident transfer scenarios with local partners, and daily case reporting)</li> </ul>	LTC Home
			<ul style="list-style-type: none"> <li>Proactive monitoring and screening of residents, staff, and visitors, including essential caregivers for COVID-19 risk</li> <li>Regular COVID-19 testing for staff and visitors, as per Ministry direction</li> <li>Ongoing training and auditing on IPAC protocols, including cohort contingency planning, and access to personal protective equipment as per CMOH Directive #5</li> <li>Ensure caregivers are re/trained in PPE techniques</li> <li>Ensure clinical oversight is in place</li> <li>Assess residents for transfer, do-not-resuscitate preferences</li> <li>Maintain accurate records of staff, caregivers, visitors, and families</li> <li>COVID-19 immunization policy outcomes monitored with individual staff follow up as appropriate; vaccine maintenance strategy in place (ideally homes order, store and administer vaccines)</li> </ul>	LTC Home
			<ul style="list-style-type: none"> <li>Clarify roles and responsibilities for local partners (OH Regions, IPAC Hubs, Home and Community Care Support Services (HCCSS)) in the COVID-19 Outbreak Management Team*</li> <li>Convene and coordinate regional/local partnership tables</li> <li>Regularly monitor key indicators as part of the risk identification and collaboration processes</li> </ul>	OH Regions

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
1.	Issue Identification and Early Management	Within first 24 hours of a suspected case	<ul style="list-style-type: none"> <li>• Resident/staff identified with COVID-19 signs/symptoms or potential exposure to suspected/confirmed case of COVID-19</li> <li>• Immediately implement enhanced IPAC measures, based on current Public Health Ontario practices and procedures, including: <ul style="list-style-type: none"> <li>• Droplet/Contact precautions initiated for residents with signs/symptoms of COVID-19 or potential exposure to suspected/confirmed case(s)</li> <li>• Implement staff and resident cohorting and isolation plan using designated spaces, as necessary; and provide direction on risk factor mitigation strategies, both inside and outside of the home</li> <li>• Mobilization of Environmental Services supports</li> <li>• Implement enhanced assessment and screening protocols for all residents, where necessary.</li> <li>• Testing initiated for: <ul style="list-style-type: none"> <li>• Suspected resident and/or staff; and</li> <li>• Other residents/staff with close contact, and anyone else designated high-risk, in accordance with public health testing guidelines</li> </ul> </li> <li>• Inform PHU, the Ministry of Long-Term Care (MLTC), and IPAC Hub</li> <li>• Immediate escalation to LTC Home corporate office with identified potential support needs, if applicable</li> </ul> </li> </ul>	LTC Home
			<ul style="list-style-type: none"> <li>• Initiate third-party IPAC assessments</li> </ul>	Most Responsible Organization (MRO) to be identified locally

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
2.	Communication and Notification of Confirmed Case	Triggered with Confirmed Case	<ul style="list-style-type: none"> <li>• Dependent on which party receives initial notification of positive results:</li> <li>• If PHU, notify LTCHs; or</li> <li>• If LTCH, report to PHU and immediately notify MLTC via Critical Incident Reporting System or the After-hours action-line; and OH Region, as applicable</li> </ul>	PHU or LTC Home
			<ul style="list-style-type: none"> <li>• Declare an outbreak</li> <li>• Investigate and manage any persons under investigation, confirmed cases, and/or outbreaks in the home</li> <li>• Provide direction on outbreak control measures to be implemented</li> <li>• Provide support for case and contact/outbreak management</li> <li>• Lead management of the outbreak in collaboration with LTCH, local partners, and MLTC</li> <li>• Deploy PHU inspections; may utilize powers under Section 22 or Section 13 of the Health Protection and Promotion Act (HPPA) to address communicable disease prevention/control issues e.g., enforce IPAC protocols</li> </ul>	PHU
			<ul style="list-style-type: none"> <li>• Implement communication plan, including notification to residents; families, regarding outbreak protocol and visiting policies; staff, including daily emails on key updates; and acute care hospitals regarding possible transfers</li> <li>• Provide information/lists of staff, visitors, residents, including those cohorted/isolated to PHU for contact tracing and safety measures</li> <li>• Restrict visits, admissions/re-admissions, as per Ministry direction</li> </ul>	LTC Home



3.	Response Planning	Within 48 hours of confirmed case	<ul style="list-style-type: none"> <li>• Activate COVID-19 Outbreak Management Team* (See Section 0) after outbreak is declared byPHU</li> <li>• Facilitate regional/community level supports to home based on available capacity at the local/regional level</li> </ul>	OH Regions
			<ul style="list-style-type: none"> <li>• Commencement of regular touchpoint calls between home, MLTC, PHU, IPAC Hub, OH Regions, and hospital partners</li> </ul>	MRO to be identified locally
			<ul style="list-style-type: none"> <li>• MLTC inspections deployed where necessary, and based on risk assessment</li> <li>• Monitor daily statistics for outbreak management</li> <li>• Provide regulatory oversight of the emergency response to determine policy instruments that mayneed to be actioned (e.g., mandatory management order, voluntary management contract)</li> </ul>	MLTC

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
4.	Outbreak Management	Within 48-72 hours of confirmed case	<ul style="list-style-type: none"> <li>Contact tracing, follow up, and case reporting</li> <li>Coordinate home outbreak testing strategy in accordance with latest guidance/directive</li> </ul>	PHU
			<ul style="list-style-type: none"> <li>Ensure ongoing cohorting of residents and staff</li> <li>Subsequent testing, as required based on PHU risk assessment</li> </ul>	LTC Home
			<ul style="list-style-type: none"> <li>Completion of Outbreak Risk and external IPAC assessments</li> <li>IPAC extender supports deployed, as needed</li> </ul>	MRO to be identified locally (PHU, IPAC Hubs and MLTC) OH Regions
			<ul style="list-style-type: none"> <li>Initiation of LTCH's on-going outbreak management processes (work occurring beyond scope of this document)</li> </ul>	LTC Home in collaboration with MLTC, PHU, IPAC Hubs, Hospitals and OH Regions
5.	Oversight	On-going	<ul style="list-style-type: none"> <li>Monitoring of recovery efforts</li> </ul>	MLTC LTC Corporate offices

## **Appendix A – Long Term Care Homes**

### **Standard Operating Procedures for COVID-19 Outbreak Management**

Under the *Long-Term Care Homes Act* (LTCHA) and its Regulations, licensees are required to:

- Ensure a safe and secure environment for residents (s. 5, LTCHA)
- Effectively prevent and manage outbreaks, including ensuring that there is:
  - An infection prevention and control program for a long-term care home (s. 86, LTCHA)
  - An outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts
  - A written plan for responding to infectious disease outbreaks (s. 229 of O. Reg. 79)
- Ensure that emergency plans are in place for the home that comply with the regulations, including:
  - Measures for dealing with emergencies
  - Procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency (s. 230 of O. Reg. 79/10)
- Ensure there is a staffing plan for its organized program of nursing services and organized program of personal support services (s. 31 of O. Reg. 79/10)
- Follow all other Ministry of Health and Ministry of Long-Term Care direction, guidance related to prevention and management of COVID-19 pandemic
- Ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act. (s. 107 of O. Reg. 79/10)
- Ensure that MLTC Director receives timely, fulsome reports as per the request of the Director pursuant to s.88 of the LTCHA

## Communication Plan

Stakeholder	Method	Purpose	Frequency	Responsibility
Caressant Care Operations Team & Head Office	Risk Alert Email  <i>See Sample</i>	Communicate the declaration of an outbreak	Upon initial outbreak notification from PHU	ED/DOC/RHM/RDO
Residents	In-person	Communicate information that is timely – home in outbreak and case counts	As required	Home staff (TBD)
Resident Council	In-person	Communicate information that is timely – home in outbreak and case counts	As required	Activities Manager
Family Council	Email Letter Phone call  <i>See Sample</i>	Communicate information that is timely – home in outbreak and case counts	As required	Activities Manager
Family Members/POA	One Call Email Phone call  <i>See Sample</i>	Communicate information that is timely but not resident-specific, case counts	Daily	ED/RHM (support from Head Office - as needed); Operations team as needed
Family Members/POA	Phone call	Clinical Communication: Resident Positive Case, Update on residents change in condition	As required	Assigned home staff (e.g. RN/RPN, DOC, ADOC, RAI, ED, RHM)
Staff	One Call Email Bulletin board Screening Desk  <i>See Sample</i>	Communicate information that is timely	Daily or as required	ED/RHM
JHSC & Union	Email Letter	Communicate information that is timely – home in	As required	ED/RHM

	Phone Call Written Notices of Staff Cases  See Sample	outbreak and case counts		
Family members/POA/Community	Website and social media updates	Communicate information that is timely	Daily or as required	Head Office (information provided by homes and or corporate)
Family Members/POA and Residents	Virtual Calls- IPAD Phone	Resident & Family Communication	As required	Ward Clerk/Activities staff/ modified staff/ RSA/SW
Media (all media requests for comment go to CMM)	Email, phone call, video conferencing	Communicate information that is timely/ respond to requests	As required	Head Office (information provided by homes and or corporate)
Initial Outbreak Corporate Call	Teams Call	Ensure all IPAC protocols are in place, determine priority and frequency of calls, review any supports needed	24 hours after outbreak declared	Set up buy DPP, attended by: ED/RHM, DOC, RDO, CPL, VPO, DOD
Priority Outbreak Corporate Calls	Teams Call	Review Status of outbreak and review of support needed	As determined by outbreak priority	Set up by DPP, attended by: ED/RHM, DOC, RDO, CPL, VPO, DOD
Potential Town Halls	Teams Call Phone Call	Communicate information that is timely/ respond to requests, questions	As requested	VPO, RDO and other staff as required

### **Risk Alert Email**

Outbreak Declared by Public Health: Yes or No

Date Outbreak Declared:

Details of the Situation:

What Steps are Being Taken in the Home to Address:

Who has been notified (i.e., residents, families, staff):

### **Family Council Letter Sample**

To Family Council,

This is to notify you that Public Health has declared a COVID-19 outbreak in our home, today, XXXX. At this time, we have X staff who have tested positive and X residents. (If residents affected include – The families of these positive residents have been notified). While this situation is concerning be assured that we are doing everything we can to keep your loved ones safe and healthy. We are working closely with Public Health and our Medical Director to ensure all policies, procedures, and practices are in place. We are committed to keeping you updated and will be sending out updates daily via our automated message system. Please visit our website at XXX for additional information.

\*This should be adjusted for your specific home scenario and put on home specific letterhead and signed by the ED.\*

### **Initial One Call Message – Families**

Hello, this message is from Caressant Care \_\_\_\_\_. This is to notify you that Public Health has declared a COVID-19 outbreak in our home, today, XXXX. At this time, we have X staff who have tested positive and X residents. (If residents affected include – The families of these positive residents have been notified). While this situation is concerning, be assured we are doing everything we can to keep your loved ones safe and healthy. We are committed to keeping you updated and will be sending out updates daily. Please visit our website at XXX for additional information.

### **Daily One Call Message – Families**

Hello, this message is from Caressant Care \_\_\_\_\_. This is a daily update regarding the current COVID-19 outbreak at our home. At this time, we have X staff who have tested positive and X residents. (If residents affected include – The families of these positive residents have been notified). While this situation is concerning, be assured we are doing everything we can to keep your loved ones safe and healthy. We are committed to keeping you updated and will be sending out updates daily. Please visit our website at XXX for additional information.

### **Initial One Call/SSC Message – Staff**

Hello, this message is from Caressant Care \_\_\_\_\_. This is to notify you that our home has been declared in a COVID-19 Outbreak, today, XXX, by Public Health. The current situation has affected X staff and X residents. While this situation is concerning, be assured we are doing everything we can to keep our residents and staff safe and healthy. As the situation evolves, we will continue to keep you updated through these messages and daily staff huddles in the home.

### **JHSC Email/Letter Notification**

Members of the JHSC,

This is to inform you of the COVID-19 outbreak that was declared by Public Health on XXX. At this time, we have X staff who have tested positive and X residents. We are working closely with Public Health, our Medical Director and the Corporate Head Office to ensure all policies, procedures and practices are in place to ensure the safety of our residents and staff.

As the situation evolves, we will continue to keep you updated. If you have any questions or concerns, please don't hesitate to bring it to our attention.

\*If you have more home specific practices that are being changed or altered and JHSC should be notified, please include it in this letter. This should be put on Homes letterhead and signed by the ED.

### **Voluntary Management Contract – Notification to Families**

Caressant Care's priority is the safety of its residents and staff. It has entered into a voluntary management contract with XXXXXXXXXX to help control the COVID-19 outbreak. A teleconference is planned for family members [on MONTH/DATE at #:##] to share information and answer your questions. Please watch for a call-in number.

To help us stay focused on caring for your loved ones, we ask that you limit calls to the home. We thank you for your continued support.

## Long-term Care Contingency Plan for Resident Care

	Routine Services At baseline to 10% below baseline	Non-Critical Services Reviewed/Optional 11-25% below baseline	Non-Critical Services Optional 26-50% below baseline	Critical Services Only More than 50% below baseline
<b>Safety</b>				
Active Screening	√	Utilize after-hours process (I.e., Doorbell system) to allow redeployment to resident care within scope	Utilize after-hours process (I.e., Doorbell system) to allow redeployment to resident care within scope	Utilize after-hours process (I.e., Doorbell system) to allow redeployment to resident care within scope
Emergency Code response per protocol	√	√	√	√
Infection Prevention and Control screening, PCRA, additional precautions	√	√	√	√
<b>Specialty Care</b>				
Renal dialysis	√	√	√	Order required for altered diet, fluid intake, medications to extend periods between dialysis (In collaboration with dialysis unit)
Enteral feeding (J-tube, Gtube)	√	√	√	√
<b>Medical Management</b> *Early engagement with Medical Coordinators (MD, NP) is key to put plans in place to identify essential medications and treatment for residents based on individual priorities and needs.				
Medication administration	√	Medications given as prescribed. Engage Medical Director and/or Pharmacy for Medication Reviews: goal is to decrease med passes and number of medications  Identify pharmacy technicians to assist as required  Medication optimization	Consult with Pharmacy and MD/NP to prioritize medication for chronic/acute pain management, insulin dependent diabetes, essential medication, and treatment for chronic disease management  Identify pharmacy technicians to assist as required	Consult with Pharmacy/MD to prioritize medication for chronic/acute pain management, insulin dependent diabetes, cardiac issues  Identify pharmacy technicians to assist as required  (Assign other treatments, i.e., vital signs)
Respond to acute medical events	√	√	√	√
Medical appointments	√	Routine appointments if operationally able  Consult with MD/NP to identify and prioritize medically essential appointments	Routine appointments if operationally able  Consult with MD/NP to identify and prioritize medically essential appointments	Routine appointments if operationally able  Consult with MD/NP to identify and prioritize medically essential appointments



Medical investigations (lab, x-ray)	√	Consult with MRP to identify priority routine investigations and medically essential investigations	Consult with MRP to identify priority routine investigations and medically essential investigations	Medically essential investigations only
Physician Assessment	√	√	In-person assessment preferred but can be done virtually	In-person assessment preferred but can be done virtually
<b>Care of Resident</b>				
Hydration and nutrition	Regular meals x3 Snacks, including hydration x 2 provided	Regular meals x3 Snacks optional (unless diabetic or supplementary nutrition included as part of care plan) Shift to tray service from dining room service if needed in affected areas  Hydration provided	Regular meals x3 Snacks optional (unless diabetic or supplementary nutrition included as part of care plan) Shift to tray services in affected areas Hydration provided	Regular meals x 3 Shift to tray services & Consider catered meals  Diabetic snack and ordered supplementary nutrition Hydration provided
Assistance with meals	√	Review seating plans to group residents together who require assistance or monitoring with meals  Identify those who have Essential Visitors in place for support at mealtimes  Look to Students/Volunteers for support  Need to capture documenting by other care team members on paper or electronically)	Residents seated together in groups for monitoring and assistance if still doing dining room services  Delegate monitoring and portering to alternate providers (i.e., RSA, Housekeeping, Activation)  Assistance with meals delegated to care team and leaders especially if transitioned to tray service  Essential Visitors to aid specific residents per established care plan  Alter staff break schedules around resident peak mealtimes  Look to Students/Volunteers for support Consider adding CSA for low-risk residents	Ratio of staff: resident to assist with meals may be decreased  Residents seated together in groups for monitoring and assistance if still doing dining room service  Delegate monitoring and portering to alternate providers (i.e., RSA, Housekeeping, Activation)  Assistance with meals delegated to care team (i.e., HCA)  Essential Visitors to help specific residents per established care plan  Alter staff break schedules around resident peak mealtimes  Look to Students/Volunteers for support

Personal Body Washing	<p>bathe or shower twice per week per Care Plan</p> <p>Consider dry shampoos, bath in a bag, shampoo in a bag resource</p>	<p>Peri-care, hand and face washing, bed baths</p> <p>Identify residents with priority need for tub baths</p> <p>Identify those who have Essential Visitors in place for support with personal washing/ADLS</p>	<p>Peri-care, hand and face washing, bedbaths</p> <p>Essential Visitors to provide assistance with personal washing/ADLS to specific residents per established care plan</p>	<p>Peri-care, hand, and face washing</p> <p>Essential Visitors to help with personal washing/ADLS to specific residents per established care plan</p>
<p>Dressing</p> <p>Always be aware of resident dignity</p>	In own clothes/pajamas	<p>es/pajamas, changed as needed</p>	<p>nts changed into own clothes and pajamas.</p> <p>change as able</p>	<p>Residents remain in personal night clothing; change as able or soiled</p>

Mouth Care	✓	✓	Frequency may be decreased	<p>As needed</p> <p>Consider non care staff or essential caregivers assist with mouth care</p>
Toileting	✓	<p>Maintain toileting schedules, change incontinence product as needed</p> <p>Identify residents at high risk for skin integrity issues and prioritize</p>	<p>Frequency may be decreased, Identify residents at high risk for skin integrity issues and prioritize</p> <p>Consider reprioritizing tasks, i.e., bed bath so incontinence product can be changed as a priority over bed baths</p>	<p>Frequency may be decreased, maximize time in brief</p> <p>Identify residents at high risk for skin integrity issues and prioritize</p> <p>Consider reprioritizing tasks, i.e., bed bath so incontinence product can be changed as a priority over bed baths</p>

Bowel Care	✓	✓	✓	✓
Wound care	Per Wound Care Plan	<p>Complex wound management, consult WCC or wound care product supplier for Wound Care Plan/products that maximize time between dressing changes</p>	<p>Complex wound management, consult WCC or wound care product suppliers for Wound Care Plan/products that maximize time between dressing changes</p>	<p>Complex wound management, consult WCC or wound care product supplier for Wound Care Plan/products that maximize time between dressing changes</p>
Mobilization/turns	✓	<p>Identify and prioritize those unable to turn/change position; continue to support residents getting into their wheelchairs and of bed as able</p> <p>For Lifts: Effort should be made to try to maintain this during the outbreak Identify &amp; prioritize those residents requiring a mechanical lift – review opportunities to</p>	<p>Frequency may be decreased Priority given to those who are unable to turn/change position without assistance; and those who need to be up in a chair/wheelchair due to skin/wound issues and to support cognitive orientation</p> <p>For Lifts: Develop schedule which includes a reduced number of transfers i.e. out of bed every 2/3 days – and a</p>	<p>Frequency may be decreased Priority given to those who are unable to turn/change position without assistance</p> <p>For Lifts: residents remain in bed with a turning and positioning schedule in place</p>

		decrease	positioning schedule other day	
Palliative/End of life Care	√	√	√	√
Essential Visitors	√	Review Essential Visitor plans and maximize care provided by Essential Visitors	Essential Visitors for identified care needs	Maximize Essential Visitors for identified care needs
<b>Care planning</b>				
Kardex	√	√	√	√
Interdisciplinary Care Plan	√	Review acuity of residents to prioritize care needs and assignments with staff available	Review acuity of residents to prioritize care needs and assignments with staff available	Review acuity of residents to prioritize care needs and assignments with staff available
Care Conference	√	Optional - priority to complex residents or admission care conference	Optional - priority to complex residents or admission care conference; explore virtual option	Postponed
Behavioural Care Planning	√	√	√ Explore Agency for 1:1/Hall monitor (Including security)	√ Explore Agency for 1:1 Constant Care/Observation or implement Hall Monitors (Including security)
<b>Assessment</b>				
Falls	√	√	√	√
Pain	√	√	√	√
Behaviour/Cognition	√	√	√	√
Monitoring of skin integrity	√	Frequency decreased to bathing schedule, priority given to residents at medium or high risk	assessments of high-risk pressure areas	Only if clinically necessary Priority should be given to immobilized residents
Routine weights and vitals	√	Routine measurements may be deferred to another shift, priority to clinically necessary measurements	Only if clinically necessary	necessary for acute event
<b>Allied Health There is a constant need to always monitor the mental health of the residents</b>				

Physiotherapy/Occupational Therapy/Registered Dietetics	√	Review care plans and identify high-risk, high-priority residents, maximize use of current care plans	Optional - priority given to those with clinical need  Staff may be reassigned to mandatory duties within their scope of practice	Essential clinical need only  Staff reassigned to mandatory duties within their scope of practice
Social Work	√	Review residents and identify priorities including those at greatest risk of social isolation and without any ECGs	Priority work only (ACP support, capacity assessments, complete adult/guardianship investigations, time sensitive documents per licensing; checking in on the most socially isolated residents)  May be redeployed to assist with resident care as directed within scope	Priority work only (ACP support, capacity assessments, complete adult guardianship investigations, time sensitive documents per licensing)  May be redeployed to assist with resident care as directed within scope

Recreational/Activity programs	√	<p>Review programs, identify high attendance, low staff demand activities</p> <p>Maximize use of HCSWs for activities when available</p> <p>Consider shifting to 1:1 programming with focus on those at greatest risk of social isolation</p>	<p>Review programs, identify high attendance, low staff demand activities</p> <p>Maximize use of HCSWs for activities when available</p> <p>Off-site outings optional</p> <p>Staff may be redeployed to assist with resident care as directed within scope</p>	<p>Review programs, identify high attendance, low staff demand activities</p> <p>Maximize use of HCSWs for activities when available</p> <p>Off-site outings cancelled</p> <p>Staff may be redeployed to assist with resident care as directed within scope</p>
<b>Documentation</b>				
Health record documentation	√	√	Charting by exception	Critical Assessments
RAI coding/Observation Week –	√	<p>Quarterly assessments if operationally able</p> <p>Full assessments required</p>	<p>Priority to full assessments only &amp; escalate to Regional Director Operations and Corporate clinical lead.</p> <p>RAI staff can be utilized to provide clinical care</p>	<p>Priority to full assessments only</p> <p>Observation period may be adjusted until staffing is yellow or green &amp; escalate to Regional Director Operations and Corporate clinical lead.</p> <p>RAI staff can be utilized to provide clinical care</p>
<b>Admissions</b>				
Admissions	Based on current directive	Based on current directive	<p>Staffing complement is yellow or green</p> <p>PP Ops and Regional Health Authority</p>	<p>Staffing complement is yellow or green</p>

Adopted from Island Health Dec 29<sup>th</sup>, 2021



## 24 HOUR COVID OUTBREAK CHECKLIST

**To be completed within first 24 hours of outbreak.**

**Please retain for your records as RDOs and CPLs may request to review this document.**

ACTIONS TO BE COMPLETED	Date and Initial when completed
<b>Clinical – Nursing</b>	
<input type="checkbox"/> If possible, move confirmed COVID-19 resident to a private room <ul style="list-style-type: none"> <li>• Immediately, place on droplet &amp; contact precautions</li> <li>• Isolate and follow Public Health directions as per length of isolation</li> </ul>	
<input type="checkbox"/> If sharing a room, isolate all residents living in the room as directed by public health. <ul style="list-style-type: none"> <li>• PPE to be used for all “Close Contact” residents.</li> <li>• PPE to be doffed and new PPE donned in between residents in the same room.</li> <li>• Residents isolating in the same room shall have curtains always closed and designated commode chairs at the bedside if available. Follow Public Health directions if testing is required.</li> </ul>	
<input type="checkbox"/> If moving the resident to an isolation room, coordinate with environmental services, if more than one resident move onto same unit in the home where possible	
<input type="checkbox"/> Set up PPE equipment cart prior to entry to the resident room(s) (Isolation cart, Precaution signage, Donning Signage, Garbage can with foot pedal, Individual linen bin, Point of Care Risk Assessment, ABHR), ensure PPE station and garbage/dirty linen are not beside each other.	
<input type="checkbox"/> Set up doffing station inside the resident room by the door (if feasible), having doffing sign posted above garbage (doffing station)	
<input type="checkbox"/> <b>Ensure N95 Masks are available and used by staff, list of staff mask fit provided to charge nurse</b>	
<input type="checkbox"/> Document the finding on the Public Health line listing form	
<input type="checkbox"/> Document the finding on in house surveillance sheet/ IPAC Module in PCC	
<input type="checkbox"/> Document assessment in resident health record for all care provided	
<input type="checkbox"/> Complete and document vital signs in progress notes/PCC	
<input type="checkbox"/> Increase resident screening for COVID-19 to Twice daily on DOCit or PCC, Including temperature.	
<input type="checkbox"/> Review and update care plan to include interventions for COVID-19 monitoring	
<input type="checkbox"/> Resident education on precautions in place. Use of COVID-19 Facts Sheets/posted signs on doors and throughout the home	
<input type="checkbox"/> Perform PCR or RAT testing on all suspect cases and roommates as directed by Public Health	
<input type="checkbox"/> Cohorting of staff to care for resident(s); Staff caring for COVID positive residents will not care for COVID negative residents. Staff caring for positive residents will have their own break areas/change areas. Where possible separate staff caring for high-risk contacts, otherwise care completed after well residents.	
<input type="checkbox"/> Delay any non-essential appointments for the resident(s) (if psych, specialist appointment, look at alternatives such as TEAMS, virtual visits). This includes probable cases sharing the room.	
<input type="checkbox"/> Daily cleaning and disinfection of resident equipment (i.e., wheelchair, walkers, cane)	
<input type="checkbox"/> Assign nursing equipment for individual resident use where possible (thermometer, O2, BP machine etc.)	
<b>Notifications – Nursing/Designate</b>	
<input type="checkbox"/> Post outbreak signage at entrance to unit including stair wells (if applicable)	
<input type="checkbox"/> Inform team members working in unit/RHA of confirmed and probable residents if roommates/spouse involved.	
<input type="checkbox"/> Education training done on PPE, donning, doffing, care procedures required, i.e., AGMPs such as medications that require aerosol require N95 respiratory	
<input type="checkbox"/> <b>Ensure all PPE including N95 Masks are available and accessible to staff (Charge RN to oversee)</b>	
<input type="checkbox"/> Inform the MD/NP/Attending Physician of confirmed case	

ACTIONS TO BE COMPLETED	Date and Initial when completed
<input type="checkbox"/> Notify Public Health; implement outbreak protocols as directed by Public Health. Follow Infection Prevention & Control measure for Outbreak Management.	
<input type="checkbox"/> Notify SDM/POA of all residents involved <input type="checkbox"/> Yes <input type="checkbox"/> No, why not _____	
<input type="checkbox"/> Review Advanced Directives with POAs and MD as required.	
<input type="checkbox"/> Notify ED/RHM/Manager on call	
<b>Notifications – ED/DOC</b>	
<input type="checkbox"/> If outbreak is declared by the PHU ( <b>suspect or confirmed</b> ) during business hours (Mon -Fri 8:30am -4:30pm) the home must immediately report to the Director by submitting a Critical Incident System (CIS) form (LTC Homes Only)	
<input type="checkbox"/> If the PHU (suspect or confirmed) declares outbreak after hours, the home must: - Call the afterhours reporting line at 1-888-999-6973 and - Complete a CIS form first thing the following business day (LTC Homes Only)	
<input type="checkbox"/> Notify Corporate Office/Risk Alert Email	
<input type="checkbox"/> Notify all other departmental managers	
<input type="checkbox"/> Notify external health providers who service residents (nursing, PT, OT, RD, SW, cleaning, private companion, essential caregivers, hairdressing etc.)	
<input type="checkbox"/> Initiate One Call to Families, POAs, or Staff. Contact RDO to initiate with head office to update website	
<input type="checkbox"/> Initiate daily huddles with staff to provide education, updates, current practices and procedures and post meeting minutes	
<input type="checkbox"/> Notify RHRA if Retirement Home	
<input type="checkbox"/> Determine Managers schedule to provide daily support in the homes including weekends and share with RDO	
<input type="checkbox"/> Post information about the outbreak and safety information on the H & S board	
<input type="checkbox"/> Hold H & S huddles 2 times per week with minutes and attendance recorded, post on H&S board	
<input type="checkbox"/> Post all new directives and policies on H & S board and share with H&S team members	
<input type="checkbox"/> Implement outbreak staff assignment sheet and post for staff to help support working assignments/cohorting including upstaffing where needed for cohorting.	
<input type="checkbox"/> Determine if 1:1 or security is need for residents who wander or may be non-complaint with isolation/IPAC protocols	
<input type="checkbox"/> Initiate MOL list and update disability Manager (Jodi) if staff cases	
<input type="checkbox"/> Designate someone to monitor and maintain inventory of supplies gowns/gloves/masks/garbage bags, wipes etc.	
<b>Cleaning – Housekeeping</b>	
<input type="checkbox"/> Cleaning of resident room for confirmed and any probable roommates – schedule as the last room(s) to clean and disinfect	
<input type="checkbox"/> Increase cleaning and disinfectant to the entire unit/floor to twice/day Follow the cleaning policies and Procedures. Recommend using high-level disinfectant	
<input type="checkbox"/> Increase cleaning of all high touch surfaces to the home	
<input type="checkbox"/> Ensure cleaning products are well stockpiled including Oxivir, Wipes etc. Order as required.	
<input type="checkbox"/> Confirm use of Mister with staff for high touch carts, heavy equipment etc.	
<b>Laundry – Nursing/Care Attendant</b>	
<input type="checkbox"/> Personal Laundry done externally/family. he laundry will be given to the screener in a closed container and disinfected prior to giving to the resident	
<input type="checkbox"/> Arrangements can be made to bring personal laundry in house. Discuss with Infection Prevention & Control Lead/designate.	
<input type="checkbox"/> Use a mister to disinfect laundry carts before sending to non-affected home areas.	
<b>Meals – Nursing/Care Attendant/Dietary</b>	
<input type="checkbox"/> Move to tray service for the whole home for suspect and confirmed outbreaks	
<input type="checkbox"/> Use disposable items for residents on tray service.	

ACTIONS TO BE COMPLETED	Date and Initial when completed
<b>Food Service Operations/ FNM/ Dietary Lead</b>	
<input type="checkbox"/> Ensure paper product supplies are sufficient for tray service and order as required	
<input type="checkbox"/> Ensure used trays and cart collection and sanitation process is implemented and educated to staff to prevent cross contamination, when returned from units	
<input type="checkbox"/> Set up stationary snack stations on the units instead of snack carts going in and out of the units	
<input type="checkbox"/> Kitchen laundry to be separated from unit laundry	
<input type="checkbox"/> Ensure dish machine sanitation is recorded and working effectively	
<b>Programs/Rehab Services/Tours</b>	
<input type="checkbox"/> Suspend group activities on the unit/floor; consider independent activities for residents. Continue program/rehab in the other units/floors. For suspect resident, healthcare worker to conduct risk assessment for each resident to determine if rehab is acute, i.e., post fracture and immediately needed. Initiate virtual visits, and individual activities as needed.	
<input type="checkbox"/> Suspend tours	
<input type="checkbox"/> Suspend move-in, transfers to another unit/RHA as directed by Public Health	
<input type="checkbox"/> Follow visiting policies and surveillance and home access policies	
<b>IPAC Lead/Designate</b>	
<input type="checkbox"/> Review and update line listing for all resident and staff cases daily and send to the PHU	
<input type="checkbox"/> Ensure all IPAC audits are increased as per policy and are assigned to specific staff for completion, and review audit results	
<input type="checkbox"/> Monitor for resident and staff test results from PHU and update line lists (determine where results are being sent to (fax line, email and to whom)	
<input type="checkbox"/> Support staff with swabbing or residents and staff as directed by PHU – post dates and times for staff	
<input type="checkbox"/> Complete twice weekly <b>PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes Audit</b>	
<input type="checkbox"/> Initiate COVID Unit where possible with red (positive) and yellow (suspect or contact) signage/barriers and cohorting	