Caressant Care Nursing and Retirement Homes Limited

Pandemic/Epidemic Plan

FEBRUARY 2022, NOVEMBER 2022, OCTOBER 2023.

Table of Contents

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 team members be knowledgeable and equipped with the necessary resources to be able to respond to the presenting situation.

An outbreak that can't be stopped or slowed, and in which the disease is spreading rapidly to many people within a localized community or region (such as a single country), is called an *epidemic*.

Goal of Plan

- To provide direction and guidance in the management of a pandemic/epidemic to team members, students, volunteers, Residents, and visitors to the Homes.
- 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/epidemic 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
An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people. Global pandemic — one that has spread over several countries or continents affecting a large number of people.	A number of cases that exceeds what would be expected. The case definition in an outbreak is dependent on the presenting signs and symptoms and circumstances. It may vary between outbreaks and vary during an outbreak. **Enteric Outbreak:** 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: • Two or more episodes of diarrhea (i.e., loose/watery bowel movements) within a 24-hour period OR • Two or more episodes of vomiting within a 24-hour period; OR • One or more episodes of diarrhea AND one or more episodes of vomiting within a 24-hour period. **Confirmed Respiratory Infection Outbreak:** • 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 • Three cases of ARI (laboratory confirmation not necessary) occurring within 48 hours with any common epidemiological link (e.g., unit, floor). **Suspect Outbreak Definition***Suspect respiratory infection outbreak: • Two cases of ARI occurring within 48 hours with any common epidemiologic link (e.g., unit, floor); OR • One laboratory-confirmed case of influenza. Note – definitions of outbreaks may change during the course of the pandemic- above are general guidance statements.

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, policies and procedures will be update and will need to be and communicated with stakeholders impacted by the change.

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. Screening practices will be largely driven by Ministry mandates or directives and may change throughout the course of the pandemic/epidemic as directives and mandates change. One of two types of screening may be implemented.

Active Screening – Active screening occurs when information is gathered from individuals to determine if they might have an infection or illness.

Passive Screening – involves individuals self-monitor and self-report potential illnesses or exposure to the infectious agents.

The tables below provide an example that outlines some steps/processes to consider when implementing a screening program.

Active Screening & Signage

#	Steps to Implement	Done
1	**All individuals entering the facility should be screened, seven days a week 24 hours a day**, including team members, essential visitors, suppliers, etc. Entry cannot be granted without screening. The screener must: • **Log all entries** to the facility • **Ask about symptoms** • Ask about potential **close contact** with symptomatic or infected individuals* • Perform **temperature check** (37.8°C or more is considered a fever) if required 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.	
2	The Home should **designate a screener during regular business hours**. 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 **daily**, including temperature checks. Log in PCC (or template if PCC not used). **Residents with symptoms or close contact are to be screened twice daily.** 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 **daily**. 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 **self-assess** if they believe they may have been infected.	

6	A **central record of all screenings** should be maintained and **reviewed by leadership daily.**	
7	Screener should **wear at a minimum mask, eye protection and gloves** or be behind plexiglass partition, and have access to alcohol-based hand rub	
8	**Failed Screening: Isolate / Do not allow to enter the Home and handle as suspected case.** The home may choose to offer PCR testing to staff prior to going home.	

Passive Screening & Signage

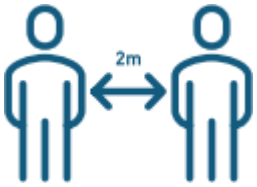
#	Steps to Implement	Done
1	**Signage across the Home:** • Reminders to perform hand hygiene • Reminders to follow physical distancing etiquette • Reminders to follow respiratory etiquette • Signs and symptoms of illness (Pandemic type) • Steps that must be taken suspected or confirmed in a staff member or a resident • PPE donning and doffing visuals, as well as disposal instructions • PCRA reminders at each room • Display reminders and information on TV monitors in each Home area • 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)	
2	**Signage at entrances:** • Indicates building access directives • Indicates that all non-essential visitors are not permitted entry until further notice (posted during an outbreak and as directed by PHU) • Symptoms and reminder not to enter the LTCH if presenting any (symptoms), go home and isolate / get tested • Reminders of precautions for team members outside the Home	
3	**Physical distancing signage** 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.	
6	Maximum room occupancy signs should be posted on all communal rooms/spaces – lounges, dining rooms, activity rooms, team member break rooms.	

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. Below outlines general recommendations as to who should and should not work from home.

Role	Recommendation
Admin / Leadership	• 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 & Operations Team
Nursing / Care	• Team members providing direct Resident care usually cannot work from home
Medical / Physician	• 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 • Remote consultations should be facilitated as much as possible • Nursing/care team members in each cohort will need to be available to facilitate video conferencing (e.g., hold tablet from room to room) • Physicians may still come on site where needed but should limit contact to a minimal number of Residents and use PPE • 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
Recreation	• Recreation team members should be cohorted and facilitate individual/in-room recreation programs • If less recreation team members are required on site, consider whether additional team members can be redeployed (e.g., to environmental services)
Environmental	• Team members performing environmental duties (cleaning and disinfection, laundry, waste management) usually cannot work from home

Dining	• Team members performing dining duties (cleaning and disinfection, laundry, waste management) usually cannot work from home • Dieticians can work from home
Pharmacy	• Team members performing pharmacy duties usually can work from home and should follow pharmacy specific policies

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 **point-of-care risk assessment (PCRA)** before any resident interaction. **<u>See Appendix</u> – Routine Practices Risk Assessment Algorithm for All Client/Patient/Resident Interactions**	
2	Ensure Residents' **goals of care and Plan for CPR** are known and up to date (e.g., DNR, funeral arrangements, etc.).	
3	Ensure **resident care is maintained** under all circumstances, including: • Personal care • Bathing can be done at the bedside, at a minimum once per week • Care of fingernails and feet may be rescheduled as required • Medication administration (compression should be completed with Pharmacy • Ongoing assessment of care needs • Routine catheter care • Skin and wound management and colostomy care • Assistance with eating as required; G-tube feeding and maintenance • Oxygen therapy as required • Residents with mobility concerns and/or at risk for skin breakdown will be repositioned • Follow outbreak management policies • Advanced care planning will be followed and updated as required • Non-urgent medical appointments can be rescheduled **Note – see appendix LTC Contingency Plan for Resident Care**	
4	Infection prevention discussions with RDO's may be needed for **increase in care/staffing** in the following areas: • Dining Services • Bathing • Laundry • Housekeeping	

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 members and/or Resident cohorting may need to be implemented 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 members 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 distance 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 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 tabletops 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.
- Team Members who carpool to work should wear masks when in the vehicle if social distancing is not possible (sit with one person in the front and another in the back).

Building & Physical Layout

#	Steps to Implement	Done
1	**Limit number of public entrances** to the building. All entrances should be monitored 24/7. • **One-single-point of entry**: Easier to implement but occasionally poses higher risk if multiple team members show at the door at the same time. • Separate entrances for different purposes (e.g., ill vs. well units): This approach requires more oversight. 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.	
2	**Access to the community** is to be limited to team members (employees, volunteers, agency staff) and essential visitors.	
3	A **process should be in place to record all who enter and exit** 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	
4	Ensure **elevators (if applicable) are disinfected between each use** (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)).	
5	**Move / remove seating** in common areas to ensure physical distancing	

6	**Reconfigure dining areas** where necessary to ensure physical distancing is maintained for all Residents. Note: Separate sittings may be required	
7	**Place markers** on the floor and across the Home to promote physical distancing (keep 2m apart), especially in high traffic areas: • E.g., Nursing station, Elevator waiting area, Bathrooms, Kitchen, team lounges, Entrance, smoking areas, etc. • See example breakroom measures below	
8	**Alcohol-based hand rub** should be placed: • Outside any room where there is a suspected or confirmed case • At the building entrance • At dining room entrances • In care areas	
9	Place the following **items at the entrance** of the building: • Alcohol-based hand rub (ABHR) with 70- 90% alcohol concentration • Tissues • Procedure masks • Proper use signage • No touch waste receptacle	

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, Essential Caregivers, and Volunteer Education:

The infection control program lead and/or designate will collaborate to deliver education to Residents, families, essential caregivers, 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 Medial Officer of Health (or designate) the name of the primary Infection Control Practitioner/Lead and backups at the Home for the outbreak investigation along with their contact information by fax.
   - Report on 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- risk alert email.

2. **Implement Infection Control Measures**

Personal Protective Equipment

- Each Home will provide an adequate supply of personal protective equipment (PPE) to team members, families, essential caregivers, volunteers, and students.
- The PPE must be always readily accessible and available to team members 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 **training on PPE use** and proper donning / doffing procedures.	
2	• **Masks:** Homes should immediately ensure that **all team members** 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. • Team members who enter Resident areas are to be given **2 masks per shift** minimum. • Team members who do not enter Resident areas are given **1 mask per shift** minimum. • Masks should be **replaced if they become soiled or moist** (e.g., when sneezing), or after interacting with a Resident with a suspected or confirmed case. • 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.	

	• **Residents** 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. • **Essential visitors** must also wear a surgical/procedure mask at all times while in the Home – the Home will provide masks at the point of entry. • **Note -masking mandates may change based on Ministry directives and or best practices**	
3	All team members should have undergone **N95 fit** testing, N95 fit testing lists, must be kept in a location accessible to registered staff.	
4	**PPE: Contact and Droplet Precautions** require PPE. Contact/Droplet precautions PPE should be available outside isolation rooms (and units where appropriate) and used when providing care to a Resident **suspected or confirmed** of having contracted the disease. Contact/Droplet precautions PPE includes: • Surgical/procedure mask • Goggles or Face shield • Gown • Gloves • N95 Masks as directed by MLTC/RHRA/PHU directives	
5	For aerosol generating medical procedures (**AGMP**), Airborne precautions should be taken, which include **Contact/Droplet precautions PPE and N95 respirators** (instead of surgical mask).	
6	Proper **receptacles** (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), **condense Resident care** where possible to reduce Resident touchpoints and limit PPE use (e.g., screening with morning care).	
8	Assess **PPE** requirements based on Resident touchpoints.	
9	Procure a minimum of **14-day supply of PPE** 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. 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. Homes should notify their RDO or head office if they are running low or have exhausted all PPE.	
10	Implement process for **tracking of PPE availability.** • Option 1: Have team submit daily count of PPE used and tally for entire facility. • Option 2: Keep count of PPE levels in storage and update as supplies are restocked/used. Report PPE levels to authorities as required.	
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
Surgical Mask	• As long as masks are not soiled, wet or dirty, they can be worn to provide care to several Residents (extended use). • Masks should be changed when soiled, or when moving between COVID-19 positive/suspected Residents and other Residents. • Masks may be kept in paper bags or between paper plates for later reuse if necessary (e.g., during break).	
Eye Protection	• 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. • Eye protection should be changed when soiled, or when moving between positive/suspected Residents and other Residents. • Reusable eye protection requires no extended use measures – it should always be washed and disinfected between uses. • 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). • Some face shields with soft foam parts should only be washed on the plastic part as the foam will get damaged if washed. • Once visible damage appears on a reusable shield, it should be disposed of.	
Gloves	• Gloves should never be reused between Residents and should be disposed of after use.	
N95 Masks	• N95 Masks should be worn when providing care to Residents with suspected or confirmed COVID-19 and when providing AGMP.	
Gowns	• Gowns should be changed between each Resident. • Reusable gowns (if applicable) should be washed between each use. • Disposable gowns can generally not be washed and should be disposed of after use. • If necessary, one gown can be used for multiple confirmed positive Residents.	

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 the 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.
- Routine practices should be applied in the handling of soiled linen (note proper PPE must be available and worn by team members).
- Routine practices should be applied to handling clinical waste.
- Use disposable equipment whenever possible.

Note- various cleaning checklists and audits are located on Surge learning (policy professional/docushare).

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. • Policies and procedures regarding staffing in Environmental Services departments should allow for surge in waste (e.g., additional PPE).	
2	Ensure that team members are familiar with waste management handling and controls: • Perform Hand Hygiene after handling waste; always use gloves. • Watch for anything sticking out of the bag or waste containers. • Never dump waste from one receptacle/bag to another • Tie garbage bags before removing from the waste receptacle, never dump waste from one bin to another. • Never reach into, or 'push' on the bag, to push the garbage down. • Carry the garbage bag away from your body (hold bag by the knot/ties) • If the bag of garbage is heavy and/or there is a chance the bag may break or leak, use a double/bag method	
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) • E.g., garbage bags	
5	Work with HR to support team morale	
6	Use required/ designated biohazardous waste bags for all biohazardous waste.	
7	Discuss with RDO the need for additional garbage collection as required.	

Laundry Process for Shared Laundry (LTC & RH):

- Ensure appropriate PPE is worn when collecting, distributing, and transporting laundry.
- The laundry cart and hamper bins must be wiped down in-between transporting of dirty and clean linen.
- There must be designated "clean" and "dirty" areas in the laundry rooms.
- Laundry is not to be mixed between the LTCH and the RH.
- Dirty laundry from the LTC home is to be transported to the door of the Retirement Home. The retirement home will open the door and bring the laundry into the home.
- Clean linen will be placed inside the doors of the LTCH by the RH team members. LTCH team members will distribute the clean linen as needed.
- There is no cross over of team members from one home to another during an outbreak

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	
Home and Community Care Support Services (HCCSS)	
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.

Note- outbreak meeting templates are located on Surge learning (docushare).

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.

Reporting Team Member Cases to Ministry of Labour
- WSIB Coordinator will send a friendly reminder that the form needs to be completed and submitted.
- In any Outbreak the form needs to be completed and faxed to the number on the 2nd page
- At the end of each day if new workers have been added to the form the form needs to be faxed.

- If nothing gets added within 3 days, there is no need to fax.
- Remember to provide accurate information on the form as the report will often drive the MOL to visit the home for an inspection

See – Caressant Car Outbreak Tracking Forms on Document Sharer under Manuals >> Outbreak Resources >> Occupational Illness Reporting,

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 **not permitted to leave the Home** 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 **outpatient visit or hospital transfer**, the Home must mask the Resident if they tolerate it.	
3	When a Resident returns, they should be **managed as per Ministry directives/guidance documents. Some actions may include:** • Application of PPE • Screen Resident before entry to the facility • Provide them with a mask. • Bring them directly to their room. • Shower the Resident (including washing hair) • Change and wash their clothes. • Put in appropriate precautions. • Isolate in room for XX day if required. • Request tray service • Screen for 48-72 hours post-arrival (or prescribed window before testing new infection) Note: For Residents with frequent outpatient visits, they may require isolation throughout the pandemic	
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.	

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 legislation (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 team 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.

Homes should keep and maintain a record of cross-trained team members from each department with their team contingency plans. Team members may be asked to completed other assigned duties outside of their regular working requirements (i.e., feeding residents, portering residents, handing out food and beverages, taking temperatures, making beds).

See – Team Contingency Plan for the Home.
See Appendix – Critical Staffing – Resident Care Contingency Plan for OLTCA

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: https://www.connexontario.ca/	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.	https://redcapsurveys.camh.ca/redcap/surveys/?s=JK4X K83AYC

Bounce Back	Free guided self-help program that is effective in helping people who are experiencing mild- to-moderate anxiety or depression, or may be feeling low, stressed, worried, irritable or angry.	https://bouncebackontario. ca/adults-19/
Wellness Together Canada	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.	https://ca.portal.gs/
AbilitiCBT	AbilitiCBT is an internet-based cognitive behavioral therapy (iCBT) program that you. can access from any device, any time.	https://ontario.abilitic bt.co m/home
BEACON	Online CBT. BEACON includes specific support. for frontline health workers.	https://info.mindbeacon.co m/btn542

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 members' 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 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 accommodation 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
• Crosswords, word search, colouring books, trivia sheets • Knitting, puzzles, painting, etc.; provide supplies. • Movies, TV, music, audiobooks (can purchase portable devices to be disinfected between uses) • Create mini activity kits with combination of above. • Hand out devotional reading / prayer for spiritual Residents • Consider online mass via TV or tablets during pandemic. • Painting rocks to leave around Home	• Bingo • Adapted board games (e.g., Yahtzee with each their own dice) • Word games / trivia • Sing-a-longs • Live music by team member • Hallway meditation • Exercises	• Leave printed quote in room. • Daily greeting / prayer over PA • Resident spa (bubbles and battery-operated candles in tub) • Short video from family • Bubbles in the garden • Flower on plate • Staff crazy hair day • Joke of the day

#	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	Prepare activities for Residents in their rooms or practicing physical distancing. This can include developing an "in room" calendar for recreation. Examples include: • Hallway / doorway bingo, fitness classes, etc. • Individual activities such as puzzles, art / painting in room, coloring, crosswords, etc. • Postcard/letter writing to family, friends, or other Residents. • Play soft noise music. • Small group outings to garden areas (with physical distancing) • Install bird feeders to provide outside visuals. • One on one activities with recreation staff • Encourage families to provide gifts such as plants, books, smart devices for calls, etc. For additional individual activities, see resources above. Activities should be tailored to individuals' preference while maintaining safety of staff and Residents a priority.	
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@caressantcare.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 daily.
- 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 Caressant 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 regarding 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 put 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	Only **essential visitors** should be allowed to enter, defined as: • 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 • Visiting a very ill or palliative Resident; these visitors must visit only the one Resident and no other Resident.	
2	Visitors must be screened at entry **(apart from Emergency responders).** • If the essential visitor fails screening, refuses to answer the questions, they will not be allowed to enter the Home. • The screener should inform them to go Home and self-isolate and contact local public health unit or telehealth for further instruction. • If any visitor becomes upset or has further questions, staff should contact a manager or delegate to handle the situation.	
3	Essential visitors must: • Only visit the Resident they are intending to visit and no other • Wear a mask at all times, unless otherwise directed (as per Ministry guidelines) • Practice physical distancing (if required) • Wear appropriate PPE if visiting a Resident suspected or infected with pandemic contagion. *Note: Best practice indicates to have all visitors wear PPE when entering the Home so as to minimize risk of infection, if possible.	
4	Staff must support the essential visitor in appropriate use of PPE: • Demonstration of putting on and taking off PPE safely, as needed. • Hand hygiene	
5	If possible, consider dedicating one room isolated in the community that is set up for visits and disinfected after each visit.	
6	Discontinue all non-essential activities (e.g., pet visitation programs, any outside group).	
7	Facilitate other methods of keeping in touch with Residents, including families and specialists, through supporting Residents with video calls and phone calls.	

9. **Mass Fatality Management**

End of Life Care
The Office of the Chief Coroner may provide directions 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 **family visit** provided they can follow safety procedures for visiting: • Screening prior to entry • One visitor at a time • Follow PPE protocols. • Maintain physical distancing from Resident's roommate. • Adhere to hand hygiene protocols	
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 **video call** with the Resident.	

Safekeeping of Resident Deceased Personal Belongings

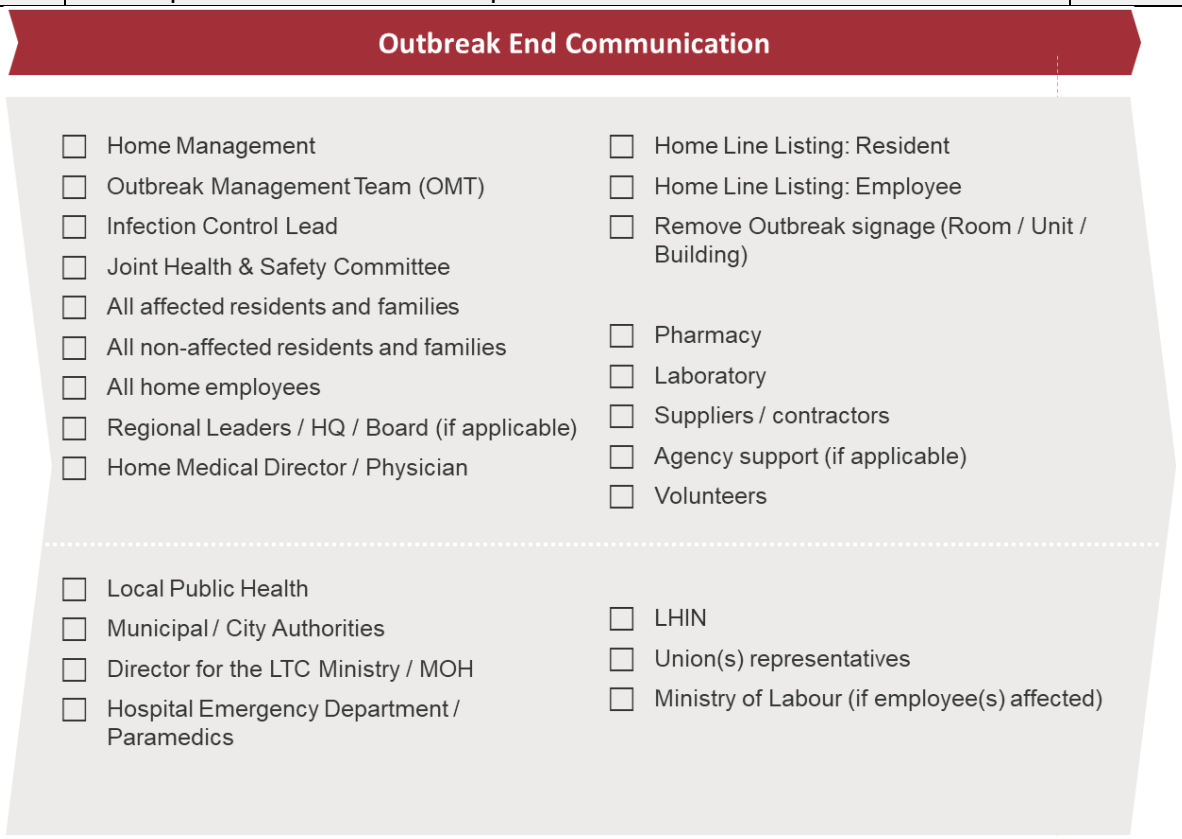
Because of limited storage space in most Homes, it is expected that the Residents POA or family members will be contacted to remove the personal belongings within 24 hours following the death of a Resident. If possible, Homes should consider a designated space to store belongings waiting to be picked up. A list of items in storage should be maintained for easy identification. 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. Homes should consider using colour coded stickers/ labels for larger furniture items (i.e., listed with resident's initials for quick identification).
- 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 **___days from the latest of:** • Date of isolation of last Resident case • Date of illness onset of last Resident case • Date of last shift at work for last team member case	

2	**Remove outbreak signage**	
3	**Outbreak end communication** 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 **lessons learned**. Update relevant documentation.	



11. **Investigate & Review the Outbreak**

Outbreak Management Meeting – templates are located on Surge Learning (Document Sharer).

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

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 30-40 secs).
- 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

Supplies and Equipment Checklist Template

Supplies and Equipment		
Category	**Item**	**#**
Hand Hygiene	Liquid Soap	
	Alcohol Hand Rinse/Sanitizer	
	Paper Towels	
Personal Protection Equipment	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	
Temperature & BP Monitoring Supplies	Thermometers (disposable covers) -Infrared	
	Stethoscopes	
	BP cuffs (Child, Adult, Large adult sizes)	
	Oximetry Machines	
Disinfectants	Disinfecting Wipes	
	Surface cleaner and disinfectant	
Cleaning	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	
Respiratory Care	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	
Suction	Disposable tips, catheters, tubing, canisters	
	Disposable manual resuscitators (BVM) & filters (various sizes)	
	Inline suction catheters	
	Portable suction	
Paper Products	Paper cups	
	Paper absorbent table cover	
	Paper plates	
	Paper bowls	
Cots/Mats		
IV Products	Solutions	
	Tubing	
Deceased Body Management	Body Bags/Shrouds	
Incontinence	Briefs, pads, wipes	

Examples of High Touch Items & Surfaces

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

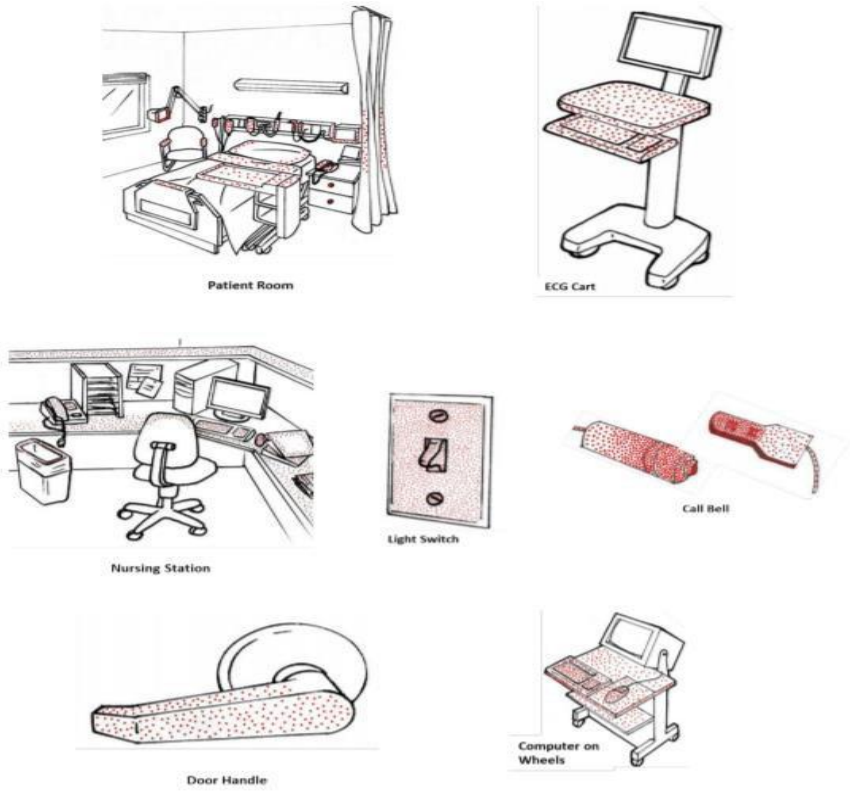


Figure 3a: Examples of High-Touch Items and Surfaces in the Health Care Environment
(Note: Dots indicate areas of highest contamination and touch)

4 Moments for Hand Hygiene

Your 4 Moments for Hand Hygiene

1 BEFORE initial patient/patient environment contact	**WHEN?**	Clean your hands when entering the patient's environment: • before touching patient or • before touching any object or furniture
	WHY?	To protect the patient/patient environment from harmful germs carried on your hands
2 BEFORE aseptic procedure	**WHEN?**	Clean your hands immediately before any aseptic procedure; for instance: changing a dressing, oral care, drawing blood, administering IV medication
	WHY?	To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3 AFTER body fluid exposure risk	**WHEN?**	Clean your hands immediately after an exposure risk to body fluids (and after glove removal)
	WHY?	To protect yourself and the health care environment from harmful patient germs
4 AFTER patient / patient environment contact	**WHEN?**	Clean your hands when leaving the patient's environment: • after touching patient or • after touching any object or furniture
	WHY?	To protect yourself and the next patient from harmful patient germs

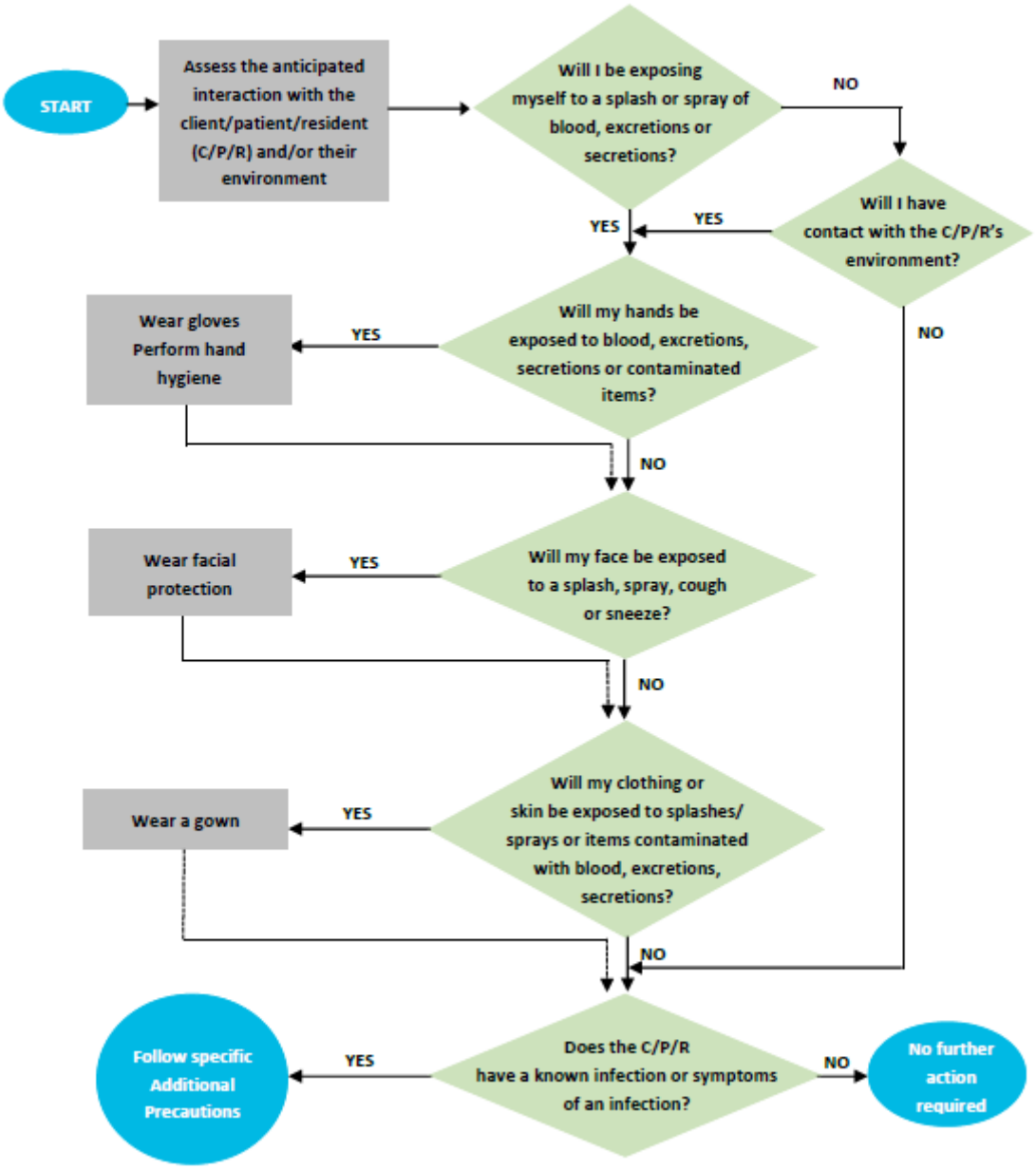
Adapted from WHO poster "Your 5 moments for Hand Hygiene," 2006.

Catalogue No. 070203 © 2011 Queen's Printer for Ontario

publichealthontario.ca/JCYH

Ontario

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



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.

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	• Outbreak Management Plan, developed in collaboration with Public Health Unit (PHU), ready to implement (includes staffing contingency plan, resident transfer scenarios with local partners, anddaily case reporting)	LTC Home
			• Proactive monitoring and screening of residents, staff, and visitors, including essential caregivers forCOVID-19 risk • Regular COVID-19 testing for staff and visitors, as per Ministry direction • Ongoing training and auditing on IPAC protocols, including cohort contingency planning, and accessto personal protective equipment as per CMOH Directive #5 • Ensure caregivers are re/trained in PPE techniques • Ensure clinical oversight is in place • Assess residents for transfer, do-not-resuscitate preferences • Maintain accurate records of staff, caregivers, visitors, and families • 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)	LTC Home
			• Clarify roles and responsibilities for local partners (OH Regions, IPAC Hubs, Home and CommunityCare Support Services (HCCSS)) in the COVID-19 Outbreak Management Team* • Convene and coordinate regional/local partnership tables • Regularly monitor key indicators as part of the risk identification and collaboration processes	OH Regions

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
1.	Issue Identification and Early Management	Within first 24 hours of a suspected case	• Resident/staff identified with COVID-19 signs/symptoms or potential exposure tosuspected/confirmed case of COVID-19 • Immediately implement enhanced IPAC measures, based on current Public Health Ontario practicesand procedures, including: • Droplet/Contact precautions initiated for residents with signs/symptoms of COVID-19 orpotential exposure to suspected/confirmed case(s) • Implement staff and resident cohorting and isolation plan using designated spaces, as necessary; and provide direction on risk factor mitigation strategies, both inside and outsideof the home • Mobilization of Environmental Services supports • Implement enhanced assessment and screening protocols for all residents, wherenecessary. • Testing initiated for: • Suspected resident and/or staff; and • Other residents/staff with close contact, and anyone else designated high-risk, in accordancewith public health testing guidelines • Inform PHU, the Ministry of Long-Term Care (MLTC), and IPAC Hub • Immediate escalation to LTC Home corporate office with identified potential support needs, ifapplicable	LTC Home
			• Initiate third-party IPAC assessments	Most Responsible Organization (MRO) to be identified locally

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
2.	Communicatio nand Notification of Confirmed Case	Triggered with Confirmed Case	• Dependent on which party receives initial notification of positive results: • If PHU, notify LTCHs; or • If LTCH, report to PHU and immediately notify MLTC via Critical Incident Reporting Systemor the After-hours action-line; and OH Region, as applicable	PHU or LTC Home
			• Declare an outbreak • Investigate and manage any persons under investigation, confirmed cases, and/or outbreaks in thehome • Provide direction on outbreak control measures to be implemented • Provide support for case and contact/outbreak management • Lead management of the outbreak in collaboration with LTCH, local partners, and MLTC • Deploy PHU inspections; may utilize powers under Section 22 or Section 13 of the Health Protectionand Promotion Act (HPPA) to address communicable disease prevention/control issues e.g., enforceIPAC protocols	PHU
			• Implement communication plan, including notification to residents; families, regarding outbreak protocol and visiting policies; staff, including daily emails on key updates; and acute care hospitalsregarding possible transfers • Provide information/lists of staff, visitors, residents, including those cohorted/isolated to PHU forcontact tracing and safety measures • Restrict visits, admissions/re-admissions, as per Ministry direction	LTC Home

3.	Response Planning	Within 48 hours of confirmed case	• Activate COVID-19 Outbreak Management Team* (See Section 0) after outbreak is declared byPHU • Facilitate regional/community level supports to home based on available capacity at the local/regional level	OH Regions
			• Commencement of regular touchpoint calls between home, MLTC, PHU, IPAC Hub, OH Regions, and hospital partners	MRO to be identified locally
			• MLTC inspections deployed where necessary, and based on risk assessment • Monitor daily statistics for outbreak management • Provide regulatory oversight of the emergency response to determine policy instruments that mayneed to be actioned (e.g., mandatory management order, voluntary management contract)	MLTC

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
4.	Outbreak Management	Within 48-72 hoursof confirmed case	• Contact tracing, follow up, and case reporting • Coordinate home outbreak testing strategy in accordance with latest guidance/directive	PHU
			• Ensure ongoing cohorting of residents and staff • Subsequent testing, as required based on PHU risk assessment	LTC Home
			• Completion of Outbreak Risk and external IPAC assessments • IPAC extender supports deployed, as needed	MRO to be identified locally (PHU, IPAC Hubs and MLTC) OH Regions
			• Initiation of LTCH's on-going outbreak management processes (work occurring beyond scope of this document)	LTC Home in collaboration withMLTC, PHU, IPAC Hubs, Hospitals and OH Regions
5.	Oversight	On-going	• Monitoring of recovery efforts	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, reportingprotocols 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 healthsignificance 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 See Sample	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 See Sample	Communicate information that is timely – home in outbreak and case counts	As required	Activities Manager
Family Members/POA	One Call Email Phone call See Sample	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 See Sample	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	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.

	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
Safety				
Active Screening	√	Utilize after-hours process (I.e., Doorbellsystem) to allow redeployment to resident care within scope	Utilize after-hours process (I.e., Doorbell system) to allow redeployment to residentcare within scope	Utilize after-hours process (I.e., Doorbellsystem) to allow redeployment to resident care within scope
Emergency Code response per protocol	√	√	√	√
Infection Prevention and Control screening, PCRA, additional precautions	√	√	√	√
Specialty Care				
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)	√	√	√	√
Medical Management *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 passesand number of medications. Identify pharmacy technicians to assistas required. Medication optimization	Consult with Pharmacy and MD/NP to prioritize medicationfor chronic/acute pain management, insulin dependent diabetes, essential medication, and treatment for chronic disease management. Identify pharmacy technicians to assist asrequired	Consult with Pharmacy/MD to prioritize medication for chronic/acute pain management, insulin dependent diabetes, cardiac issues. Identify pharmacy technicians toassist as required. (Assign other treatments, i.e., vital signs)
Respond to acute medical events	√	√	√	√
Medical appointments	√	Routine appointments if operationallyable Consult with MD/NP to identify andprioritize medically essential appointments	Routine appointments if operationallyable Consult with MD/NP to identify andprioritize medically essential appointments	Routine appointments if operationally able Consult with MD/NPto identify andprioritize medically essential appointments

Medical investigations (lab, x-ray)	√	Consult with MRP to identify priorityroutine investigations and medically essential investigations	Consult with MRP to identify priorityroutine 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
Care of Resident				
Hydration and nutrition	Regularmeals x3 Snacks, including hydration x 2 provided	Regular meals x3 Snacks optional (unless diabetic or supplementary nutrition included as partof care plan) Shift to tray service from dining roomservice if needed in affected areas. Hydration provided	Regular meals x3 Snacks optional (unless diabetic or supplementary nutrition included as part ofcare plan) Shift to tray services in affected areasHydration 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 residentstogether who require assistance or monitoring with meals. Identify those who have Essential Visitorsin place for support at mealtimes. Look to Students/Volunteers for support. Need to capture documenting by other careteam members on paper or electronically)	Residents seated together in groups formonitoring 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 transitionedto 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 withmeals may be decreased. Residents seated together in groups formonitoring and assistance if still doing dining room service. Delegate monitoring and portering to alternate providers (i.e., RSA, Housekeeping, Activation) Assistance with meals delegated tocare team (i.e., HCA) Essential Visitors to help specific residents per established care plan. Alter staff break schedules aroundresident peak mealtimes. Look to Students/Volunteers for support

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

Mouth Care	√	√	Frequency may be decreased	As needed. Consider non care staff or essential caregivers assist with mouth care
Toileting	√	Maintain toileting schedules, changeincontinence product as needed. Identify residents at high risk for skin integrity issues and prioritize	Frequency may be decreased, Identify residents at high risk for skinintegrity issues and prioritize. Consider reprioritizing tasks, i.e., bed bath soincont product can be changed as a priorityover bed baths	requency may be decreased, maximize time in brief. Identify residents at high risk for skin integrity issues and prioritize. Consider reprioritizing tasks, i.e., bed bath so incont product can be changed as a priority over bed baths

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

		decrease	positioning schedule other day	
Palliative/End of life Care	√	√	√	√
Essential Visitors	√	Review Essential Visitor plans and maximize care provided by EssentialVisitors	tial Visitors for identifiedcare needs	mize Essential Visitors for identified care needs
Care planning				
Kardex	√	√	√	√
Interdisciplinary Care Plan	√	Review acuity of residents to prioritizecare needs and assignments with staff available	Review acuity of residents to prioritizecare needs and assignments with staff available	Review acuity of residents to prioritizecare needs and assignments with staffavailable
Care Conference	√	nal - priority to complex residentsor admission care conference	Optional - priority to complex residents oradmission 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 HallMonitors (Including security)
Assessment				
Falls	√	√	√	√
Pain	√	√	√	√
Behaviour/Cognition	√	√	√	√
Monitoring of skin integrity	√	Frequency decreased to bathing schedule, priority given to residents atmedium or high risk	e assessments of high-riskpressure areas	Only if clinically necessary Priorityshould be given to immobilized residents
Routine weights and vitals	√	Routine measurements may be deferredto another shift, priority to clinically necessary measurements	Only if clinically necessary	necessary for acuteevent
Allied Health There is a constant need to always monitor the mental health of the residents				

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 withclinical need. Staff may be reassigned to mandatoryduties within their scope of practice	Essential clinical need only Staff reassigned to mandatory dutieswithin their scope of practice
Social Work	√	Review residents and identify prioritiesincluding those t great is 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 isolatedresidents) 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	√	Review programs, identify high attendance, low staff demand activities. Maximize use of HCSWs for activitieswhen available Consider shifting to 1:1 programmingwith focus on those at greatest risk ofsocial isolation	Review programs, identify high attendance, low staff demand activitiesMaximize use of HCSWs for activities when available Off-site outings optional. Staff may be redeployed to assist withresident care as directed within scope	Review programs, identify high attendance, low staff demand activitiesMaximize use of HCSWs for activities when available Off-siteoutings cancelled. Staff may be redeployed to assist withresident care as directed within scope
Documentation				
Health record documentation	√	√	Charting by exception	Critical Assessments
RAI coding/Observation Week –	√	Quarterly assessments if operationally able Full assessments required	Priority to full assessments only & escalate to Regional Director Operations and Corporate clinical lead. RAI staff can be utilized toprovide clinical care	Priority to full assessments only Observation period may be adjusted until staffing is yellow or green & escalate to Regional Director Operations and Corporate clinical lead. RAI staff can be utilized to provide clinical care
Admissions				
Admissions	Based on current directive	Based on current directive	fing complement is yellowor green. VP Ops and Regional Health Authority	ntil staffing complement is yellow or green

Adopted from Island HealthDec 29th, 2021