Infection Prevention and Control (IPAC)

Pandemic/Epidemic Plan

Contents

Purpose

This pandemic plan documents the guiding principles the organization will follow in the event of a pandemic.

A pandemic plan is a documented strategy for how the Glebe Centre plans to provide essential services when there is a widespread outbreak of an infectious disease.

Goals and Objectives

To provide direction and guidance in the management of a pandemic/epidemic to staff, students, volunteers, residents, and visitors to the Glebe Centre.

- To reduce the spread of virus/contagion among residents, staff, family members and volunteers.
- To maintain essential care and services for residents
- To ensure that workplace health and safety standards are maintained to support staff, families and volunteers in meeting resident care and service needs.

Definitions

A **Pandemic** is when a new disease or new strain of an existing disease spreads worldwide. Viral respiratory diseases, such as new influenza viruses or COVID-19 are the ones most likely to cause a pandemic.

An **Epidemic** is a sudden increase in the number of cases of a disease in a specific area. Epidemics can be caused by a number of factors, including the introduction of a new disease, an increase in the virulence of an existing disease, or a change in how the disease is transmitted.

An **Outbreak** is when there are more disease cases than what is usually expected: For a given time (e.g., within 2 weeks) Within a specific location (e.g., linked by institution, affiliation, exposure, small geographic area) For a target population (e.g., students, long-term care residents

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 or more resident cases of test-confirmed acute respiratory infections (ARI) with symptom onset within 48 hours and an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission within the setting.

OR

• Three or more resident cases of ARI with symptom onset within 48 hours and an epidemiological link suggestive of transmission within the setting and

testing is not available or all negatived.

Suspected Respiratory Outbreak

Two resident cases of ARI with symptom onset within 48 hours with an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission within the setting AND testing is not available or all negative.

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.

Internal Policies & Procedures

In addition to this pandemic guide, all staff and management should be familiar with and apply the existing policies, including but not limited to:

- Outbreak Management
- IPAC program policy
- Handy Hygiene
- Donning & Doffing PPE
- Admission
- Dining
- Laundry
- Reception of Goods
- Existing Daily Tools/Checklists
- Staffing 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 Home. Please note that all these policies apply until they are reversed.

When new guidance involves significant change, ensure this document is updated (including updates tracking), and communicate the change with stakeholders impacted by the change.

Prevention and Preparedness

Preparedness

This section outlines the best practices and guidelines all staff should be familiar with to prevent a 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** 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

Number #	Screening	Note
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., the 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 for symptoms twice daily when in the outbreak**,** and once daily when not in outbreak, including temperature checks. Log in PCC (or template if PCC is not used). Screening may be increased based on MLTC or PHU directives. Temperature checks may be included or removed as per MLTC or PHU directives.	
4.	All staff and essential visitors are to be screened daily. Screening may include temperature checks as per MLTC or PHU directives. Screening may be increased based on MLTC 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	The screener should wear at a minimum mask, eye protection and gloves or be behind a 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

Number #	Signage	Note
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 aresident • PPE donning and doffing visuals, as well as disposal instructions • PCRA reminders in each room Visual reminders to perform point of care risk assessment (PCRA) prior to any resident interaction (recommend having at med carts, nursing stations, entry of each unit)	
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 staff outside the Home • Display reminders and information on TV monitors	
3.	**Physical distancing signage** available in areas where staff or Residents tend to congregate (e.g., break areas, nursing station, computers, building entrance, etc.).	
4.	Elevator signage to indicate maximum occupancy for physical distancing	
5.	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 m physical distance

Working from Home

Who Should Work from Home?

The Glebe Centre 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 staff health and wellness. The below outlines general recommendations as to who should and shouldn't work from home.

Role	Recommendation
Management	Some staff in administrative functions may be able to work from home, decisions should be evaluated on a case-by-case basis by the CEO.
Nursing Care	Staff providing direct resident care cannot work from home.
Medical/MD/NP	Physicians/NPs and specialists may not be co-horted 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 staff in each cohort will need to be available to facilitate videoconferencing (e.g., conduct consultation with tablet). 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 oftransmission if onsite.
Recreation	Recreation staff should be cohorted and facilitate on the home areas recreation programs If less recreation staff is required on site, consider whether

	additional staff can be redeployed
Environmental	Staff performing environmental duties (cleaning and disinfection, laundry, waste management) cannot work from home
Dining	Staff performing dining duties cannot work from home Dieticians can work from home
Pharmacy	Staff performing pharmacy duties usually can work from home and should follow pharmacy specific policies

Requirements for Staff Working from Home

Tools and Equipment
• Computer (policy should specify whether personal devices are allowed, or the Home will provide devices) • Internet access • 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 Procedure
• 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 home may need to implement staff contingency plans in order 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.

Number #	Steps to Implement	Completed
1.	Every health care worker must perform a point-of-care risk assessment(PCRA) before any resident interaction. **https://www.publichealthontario.ca/-/media/documents/r/2012/rpap-risk-assessment.pdf?la=en**	
2.	Ensure Residents' care goals / advanced directives 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; feeding tube and maintenance • Oxygen therapy as required • Residents with mobility concerns and/or at risk for skin breakdown will berepositioned • Follow outbreak management policies • Advanced care planning will be followed and updated as required • Non-urgent medical appointments can be rescheduled	
4	Infection prevention discussions with a OMT 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 staff 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 health care worker in their interaction with the resident and resident environment.

Cohorting – Staff and Residents

In the event of a pandemic, staff and/or resident cohorting may need to be implemented in order to contain the spread of the virus/contagion. The Glebe Centre has a plan for staff and resident cohorting (to the best of our ability) as part of our approach to preparedness as well as to prevent the spread of the outbreak.

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.

Outbreak Area: The outbreak area has cases or may have cases in the near future, such as floors/units where there are Residents or staff with symptoms or who may have been exposed to the outbreak.

Non-outbreak area is the remainder of the facility. In some outbreaks, the whole facility is considered the outbreak area.

Resident 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, cohorting should be implemented by keeping residents in the same unit.

Resident Cohorting may Include:

- Alternative accommodation in the home to maintain physical distancing of 2 meters.
- Resident cohorting by outbreak status.
- Consideration to ensuring Residents programs and dining promote social distancing
- Workflow should be organized so care for the cohort is grouped together, to

minimize repeated visitsto the same cohort.
- If staff must move between the cohorts, they should only go from the lowest risk cohort to the highestrisk cohorts if at all possible.

Staff Cohorting

Having a staff member look after only one cohort of Residents and not moving from one cohort to another during a shift. 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 staff looking after only the Residents in one cohort and not moving from one cohort to another during a shift.

Staff Cohorting may Include:

- Designated staff will work consistently in specific areas in the Home as part of preparedness.
- Staff members should be assigned to care for only one cohort of Residents during each shift if at all possible.
- Over the course of the outbreak, if possible, staff members should work with only one cohort, and notswitch between cohorts.
- If in an outbreak, will ensure that staff have access to supplies and rest areas and do not access other areas thatare not in outbreak.

Staff breaks room

It is very important for staff to stay at least two meters from each otherat all times, including during breaks and meals. Frequently-touched staff room surfaces like table tops and chair arm rests should be cleaned between use.

Staff working with one cohort should remain separate from each other and from staff members working with other cohorts**.** Each staff cohort should use the staff room at separate times if possible.

Building & Physical Layout

Number	Entrance/Dining Area	Note
1.	Limited number of public entrances to the building. All entrances should be monitored 24/7. One-single-point of entry: only one entrance is accessible for all staff and visitors, and all others are locked with signage redirecting to the main access. Exceptions can be made for the cook who comes early at 0400 am.	
2.	A process in place to record all who enter and exit the Home, including essential visitors (full-name, contact information, resident visited, in/out time). Record is kept for 30 days.	
3.	Ensure elevators are disinfected at least 2 times per shift **(**buttons, bars, anything touched with Oxivir wipes) and avoid leaning on walls of the elevator. Place disinfecting wipes in or near the elevator.	
4.	Move / remove seating in common areas to ensure physical distancing.	
5.	Reconfigure dining areas where necessary to ensure physical distancing is maintained for all residents. Note: Separate sittings may be required or using activity room.	
6.	Hand sanitizer should be placed: • In resident's room • Hallway • At the building entrance • At dining room entrances • In care areas •	
7.	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 • Garbage can	

Education and Training

To ensure that Health Care Workers (HCWs) have the knowledge and skills to reduce transmission, The Glebe Centre will provide appropriate education and training. Ongoing education and support are key to workplace health and safety.

Education programs are developed in consultation with and are reviewed by the Joint Health and Safety Committee /Health and Safety Representative.

Employee education

Should include but is not limited to the following:

- Routine IPAC Practices
- Hand Hygiene – How to Hand wash, How to Hand Rub Fact Sheet - English (publichealthontario.ca)
- Point of Care Risk Assessment (PCRA) Checklist for Office Infection Prevention and Control (publichealthontario.ca)
- Donning & Doffing of PPE Putting on Full Personal Protective Equipment | Public Health Ontario Taking off Full Personal Protective Equipment | Public Health Ontario
- Cough Etiquette (if required)
- Infection Control & Prevention Measures
- Social Distancing (if required)
- How to Self-Isolate (if required)

Resident, Family and Volunteer Education

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

- Hand Hygiene – How to Hand wash, How to Hand Rub
- Cough Etiquette (if required)
- Infection Control & Prevention Measures
- Donning and Removing of Personal Protective Equipment (PPE)
- How to Self-Isolate (if required)
- Social Distancing (if required)
- 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- Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (IPAC)

Response Levels During a Pandemic

Pandemic Activity in the Community

The local Public Health Unit will notify the facility that the pandemic has spread into the area
The Home will activate its emergency plan if appropriate
The Home will maintain active surveillance using the local Public Health surveillance forms.

Pandemic Activity in the Home

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

1) Notify the local Medical Officer of Health or their designate
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) Mass Fatality Management
12) Implement control measures for visitors
13) When the outbreak is over- done by OPH
14) Investigate & review the outbreak

Notifying the Local Medical Officer of Health or Designate of Potential Outbreak

- ✓ Notify the local authorities 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 submission 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 the Glebe Centre community - risk alert email.

Implement Infection Control Measure

Personal Protective Equipment

The Home will provide an adequate supply of personal protective equipment (PPE) to staff, family, volunteers and students.

The PPE must be readily accessible and available to staff at all times during the suspected outbreak, heightened surveillance and declared outbreaks. The Home will attempt to maintain a 2-week supply of PPE. During a pandemic outbreak, the Home will have access to the MOHLTC PPE stockpile by initiation of contact with the Ministry Emergency Operations Centre.

Number #	PPE	Completed
1.	When employees are hired, they should receive basic training on PPE use and proper donning and doffing procedures. This training should be repeated annually and as needed.	
2.	**Masks:** Homes should immediately ensure that **all**	

	staff wear procedure masks at all times, in outbreak and those not in outbreak. Masks should be placed at the entry to the Home. 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 staff who are taking breaks, the medical mask may be removed but a minimum two-meter distance should be maintained from others **Residents** should be encouraging to wear a mask as tolerated (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 staff should have undergone **N95 fit** testing. N95 fit testing lists, must be kept in a location accessible to registered staff and management team	
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 •	
5.	For aerosol generating medical procedures (**AGMP**), Airborne precautions should be taken, which include **Aerosol Contact Precautions- PPE and N95 respirators** (instead of Medical mask). This includes residents on CPAP. N95 should be worn by staff when CPAP is in use.	
6.	Garbage should be put in place to gather used PPE inside	

	the isolation room near the exit, and no PPE is to be reused.	
7.	When Droplet and Contact precautions are in place (suspected or confirmed cases), **condense resident care** where possible to reduce resident touchpoints and limit PPEuse (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 units in outbreak.	
10.	Implement process for **tracking of PPE availability.** Keep count of PPE levels in storage and update as supplies arerestocked/used Report PPE levels to authorities as required. Purchaser will keep track of PPE expiry date and ensure rotation of PPE stock to avoid PPE waste.	
11.	PPE should be stored in a secure location to avoid unnecessary use.	

Note

PPE may frighten Residents, particularly those who are cognitively impaired. Staff can introduce themselves at the resident's doorway prior to donning and notify the resident that they will be entering the room with a faceshield and gown.

All staff should be trained on donning and doffing procedures as outlined below, and signage should be placednear donning/doffing stations to remind staff of steps. Regular audits and refresher training should be performed throughout a pandemic. Refer to Appendix B for Donning & Doffing of Personal Protective Equipment (PPE).

PPE Conservation: Extended Use and Reuse

PPE shortages may occur in pandemics. If the Home is experiencing shortages, we may choose to implement the following conservation measures.

PPE	Conservation Measure	Completed
Medical mask	As long as masks are not soiled, wet or dirty, they can be worn to provide care to several asymptomatic Residents (extended use). Masks should be changed when soiled, or when moving between positive/suspected Residents Except when deemed necessary during PCRA	
Eye Protection	Eye protection should be changed 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. 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 immediately after use.	
Gowns	Gowns should be changed between each Resident. Disposable gowns cannot be washed and should be disposed immediately after use.	
N95 Masks	Always follow OPH or Ministry guidelines when to wear N-95 Mask	

Note: PPE should not be reused unless there is a shortage. Always follow direction from IPAC Officer or designate when it comes to PPE conservation.

Hand Hygiene program

Hand Hygiene is the responsibility of everyone. 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. Alcohol-based hand rub (ABHR) is available throughout the Glebe Centre and in all resident rooms and at the point-of-care.

Major components of Glebe's HH program include: audits, education, supports for

residents and hand care (see 4 Moments of hand hygiene).

Ensuring non-expired testing kits are available and stored appropriately, and plans are in place for taking specimens.

Cleaning & Disinfecting

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

- ✓ The Glebe 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 and disinfected between resident use
- ✓ All frequently touched surfaces should be cleaned daily x 2 (See Appendix F Daily High-Touch Point Cleaning Checklist).
- ✓ Routine practices should be applied in the handling of soiled linen (note proper PPE must be available and worn by staff). See Appendix H, Laundry Audit.
- ✓ Routine practices should be applied to handling clinical wastes
- ✓ Use disposable equipment whenever possible.

Waste Management

Following routine practices such as:

- ✓ Ensure staff are follow Routine Practices
- ✓ PPE should be worn when handling (open) soiled linen, including: gowns, gloves, face shield
- ✓ Consider all soiled laundry / clothing as potentially infectious
- ✓ Ensure soiled linen / clothing does not contaminate clean linen

#	Waste	Completed
1.	Put in place waste management schedule reflecting needs of the community duringthe pandemic times Policies and procedures regarding staffing in Environmental Services departments should allow for surge in waste (e.g., additional PPE).	
2.	Ensure that staff is 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 wastefrom 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 Ensure waste and linen bags are replace prior to overfilling/becoming to heavy	
3.	Ensure that every resident room/bathroom has a garbage can.	
4.	Ensure that waste management has necessary supplies (including planning and re-ordering) E.g., garbage bags	
5.	Clearly mark bags that contain biohazard	
6.	Use required/ designated biohazardous waste bags for all biohazardous waste	
7.	Work with HR to support employee morale	

Communication

The Home will notify those individuals associated with the facility.

Individuals to Contact	Contacted
Medical Director/Attending Physicians/Nurse Practitioners	
Homes Management Team – CEO, DOC, DO, HR, DFS, DES, Dietary, Rec/Program	
IPAC Lead & IPAC Committee	
Ministry of Long-Term Care (Initiate Critical Incident Report)	
Ministry of Labour (if staff affected)	
IDC&S Team	
Frontline Staff/PT	
Unions & Union Representatives	
Residents & Families	
Volunteers	
Pharmacy	
Lab Services	
Resident & Family Councils	
LHIN	
Other Service Providers/Contracted Services - OT, foot care, hairdresser	

Outbreak Management Team (OMT)

The Outbreak Management Team (OMT) is responsible for:

- Identifying, declaring with the local public health unit 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 Ottawa Public Health Department/Ministry of Health or as instructed by authorities; the Chief Executive Officer (CEO) or designate to activate the 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 ofprecautions and who is responsible for posting
- Confirm Antiviral Meds as required
- Confirm implementation of staff exclusion policy as required
- Confirm implementation of staffing contingency plan as required
- Confirm process for specimen collection
- Identify any further notifications
- Review communication plans – internal & external
- Determine if in-service sessions for staff are required and who will conduct them
- Confirm how and when daily communication will take place with OPH Unit and the Home
- Confirm who is responsible for PHU update daily
- Line listing – update as necessary and share with OPH daily

- Review control measures to prevent spread
- Enforce use of PPE
- Initiate screening if required by OPH
- Confirm frequency and times of outbreak meetings

See Appendix E, Initial Pandemic Outbreak Meeting Template

Monitor Outbreak/Surveillance

- Home should use the tracking surveillance forms approved by the OPH
- 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, staff, volunteers
- Home will keep separate line listing surveillance forms for: each home area
- Ensure families, residents, staff and stakeholders are updated on progression of the outbreak. Ensure outbreak updates are communicates with OPH such as new cases, deaths, hospitalizations, staffing and PPE supply.

Resident Surveillance

The following information will be collected:

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

Staff Surveillance

The following information will be collected:

- New staff cases
- Staff who have recovered and return to work date
- Status of ill staff
- # of staff receiving anti-viral
- Adverse reactions to any prescribed anti-viral
- Status of NP swabs
- Deaths

Reporting

Staff Member

In any outbreak that involves staff, the line listing will be faxed to the Ministry of Labour.

• At the end of each day if new workers have been added to the form the form needs to be faxed.

• Remember to provide accurate information on the form as the report will often drive the MOL to visit the home for an inspection

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:

#	Resident Absences	Completed
1.	Residents **permission to leave the Home** for short or long-term absences,vacations, or appointments (e.g., visit family or friends), for prescribed medical reasons (e.g., dialysis, transfusions, etc.). will be largely driven by Ministry mandates or directives and may change throughout the course of the pandemic/epidemic as directives and mandates change.	

2.	If a resident leaves the Home for an **outpatient visit or hospital transfer**, the Home must encourage resident to wear medical mask 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 is referred to a hospital, the Home should coordinate with the hospital, local OPH, paramedic services and the resident to maintain appropriate isolation precautions during travel.	
5.	Notify the family if the resident is to be transferred to the hospital.	
6.	Patient transfer services should not be used to transfer a suspected or confirmed case.	

Transfer to the Hospital will be required if:

The Medical Director/NP/POA has determined that transfer to the hospital is necessary.

Implement Control Measures for staff and volunteers

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 labor 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
- Training of staff
- Redeployment of staff
- Vacation entitlements

Staffing Contingency Plan

It is anticipated that all staff will continue to report for 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 staff, volunteers, family members & students. Specific services and programs may be suspended to make additional staff available to assist with the essential services.

Alternate work assignments may be considered in order to maintain essential services. Refer to Appendix L, Long-term Care Contingency Plan for Resident Care. The DOC/designate will maintain the list of cross-trained staff.

Staff Support Services

In conjunction with the Homes CEO, and HR, decisions regarding the availability of additional staff support services will be made. Some of the support that could be provided may include: Transportation services; Meals; Rest areas between overtime shifts.

Staff Wellness Support

Frontline workers 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
HR department		Ext 312
ConnexOntario Ontario Mental Health Helpline	24/7	1-866-531-2600 Chat also available: https://www.connexontario.ca/
Canadian Mental Health Association Crisis Help Line	24/7	1- 833-456-4566 Also available via text: 45645
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=JK4XK83AYC
Bounce Back	Free guided self-help program that's effective in helping people who are experiencing mild- to-moderate anxiety or depression, or may be feeling low, stressed, worried, irritable or angry.	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.abilitiicbt.com/home
BEACON	Online CBT BEACON includes specific support for frontline health workers.	https://info.mindbeacon.com/btn542

Managing Staff Working at Other Facilities

The management of staff members working at other LTC or RH's will largely be guided by the local Public Health Unit and from government/legislated directives. During a pandemic the illness may will be widely circulating and probably affecting many facilities.

Deploying Staff

Staff may need to be deployed to other designated work areas in the Home, and/or may be asked to work at another home areas. Prior to deploying staff to another unit or department, Home should consider that staff will be deployed in order to ensure adequate levels of care.

JOHSC & Unions

It is the expectation that in the event of any pandemic, 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, staff illness/accommodation needs etc. Regular meetings and information sharing with both groups is key, some reminders for staff include:

- ✓ For physical health and wellness related concerns, staff can contact a healthcare professional by contacting **Telehealth Ontario at 1-866-797-0000**
- ✓ If staff 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 staff member **suspects they may be ill or test positive,** they should not come to work and should notify their supervisor/designate. The supervisor/designate in consultation with the local PHU will confirm when the employee 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 HR/WSIB.
- ✓ All staff request for work accommodations should be discussed with the HR department.

Recreation

The Recreation team plays an essential role in ensuring resident wellbeing and morale throughout the pandemic. While most typical activities are suspended, Recreation staff can develop activities for small groups, one-on-one, and in room. Recreation staff should clear activities with IPAC team, 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, coloring books, trivia sheets; paintings Pandemic pain Knitting, puzzles, painting, etc.; provide supplies Movies, TV, music, audiobooks (to be disinfected between uses) Create mini activity kits with a combination of the above Hand out devotional reading/prayer for spiritual Residents Consider online mass via during pandemic	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

#	Activity	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, 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 toremain 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 theirpersonal device to record images of Residents.	
7.	Work with HR to support staff 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 individually	

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 Home. The DOC/designate should engage in discussions with the pharmacy provider to consider implementation of the following:

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

Antivirals

Antiviral and vaccine medications 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, ECG 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 Director through the facility Pharmacy provider.

The Infection Control Manager/designate will maintain a list of:

- ✓ Vaccinated staff, non-vaccinated staff

- ✓ Staff that received antiviral, staff that refused antiviral
- ✓ Vaccinated Residents
- ✓ Residents that received antiviral, Residents that refused antiviral
- ✓ Consents for both staff and Residents

Antiviral Storage/Tracking

In the event that antiviral medication is available and distributed to Home for administration, there may be guidelines from the OPH or government on the storage and tracking requirements. Home may need to ensure that at a minimum the following are in place:

- ✓ Home must 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 q2 times daily by the nurse and a temperature log will be kept for 3 years.
- ✓ The vaccine fridge is connected to an emergency outlet to avoid Cold Chain failure in the eventof a power outage.

Media & Communication

It is critical that messaging is consistent during uncertain times, and so the Home requires that no employees communicate with the press. All requests should be redirected to the CEO/ Director of Operation. All staff should be wary of misinformation in rapidly evolving situations of a pandemic. Staff should always refer to the most up-to-date information from official sources such as the Ministry of Health and Public HealthOntario. 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, staff 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 manager of IPAC will provide a status report about pandemic activity in the Home on a daily basis. The Outbreak team will meet daily. The team has the overall responsibility for overseeing, directing and ensuring that outbreak practices and procedures are initiatedand communicated to all staff. IPAC manager/designed will post information on PCC and on the Infection Control Board in the elevator. The IPAC team/nurse will communicate pandemic information and updates obtained at the teammeeting to their staff via the following:

- ✓ Huddles in the home areas at the shift reports
- ✓ Postage signage at entry/exit
- ✓ Team meetings
- ✓ Posted information on the Infection Control Board (elevator)

Communications – External

All general inquiries regarding the pandemic should be directed to the local Public Health Unit. Director of Operation/designed shall be responsible for providing all information to the external stakeholders. Home may wish to survey their family members and volunteers in regards to their ability tovolunteer to assist during a pandemic (i.e., screener). The Registered Staff on each unit is responsible for contacting and responding to family's questions regarding a health status of the resident.

Information about the pandemic and the homes actions will be shared with Residents, Families, Volunteers, and Visitors via the following:

- ✓ Signage posted on entry/exit
- ✓ Signage posted in the elevator
- ✓ E-mail from the Home/Corporation
- ✓ Social Media (Facebook, corporate website)
- ✓ One-Call

Emergency Supplies/Stockpiling Plans

During a Pandemic, The Home will need large quantities of both equipment and supplies to provide care and to protect our workers. Demand for these items will be high worldwide and normal supply chains may break down. Preparing for and responding to an outbreak requires critical supplies outlined in the below section. The Home should determine its 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. Homes should maintain a minimum of a 14-day pandemic supply, a 7-day stockpile of non-perishable food items, and will maintain 24 hours' worth of potable water for Residents and staff. All supplies are to be checked for expiration dates and rotated on a regular basis to prevent stock expiration.

Refer to Appendix M: 24 Hour Outbreak Checklist.

Essential Supplies

PPE supplies	Count
Surgical mask	
N95 respirators	
Gloves (all sizes)	
Gowns-disposable	
Face shields	
Goggles	
Hand Sanitizer	
Disposable Wipes/ Disinfectant Wipes	

Dining Supplies

Supplies	Count
Extra tables	
Paper/disposable plates, cups and cutlery	
Trays	
Additional carts to allow use of separate equipment for each home areas	
Additional containers	

Food Supplies

Supplies	Count
Pandemic menu (on hot meal)	
Thickeners	
Supplements	

Other

Supplies	Count
Sphygmomanometer	
Thermometers and scan cover	
Garbage cans	
Oximeter machines	

Visitor Management

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

#	Visitors	Completed
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, Ministry). 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 designate to handle the situation.	
3.	Essential visitors must: ✓ Only visit the resident they are intending to visit and no other ✓ Practice physical distancing (if required) ✓ Wear appropriate PPE if visiting a resident suspected or infected with pandemic contagion ✓	
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.	Discontinue all non-essential activities (e.g., pet visitation programs, any outside group).	

End of Life Care

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

Death Pronouncement

According to the College of Nurses of Ontario (CNO), 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/POA 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 are allowed into the Home for Residents who are nearing the end of life. Visiting is restricted to the resident's room.

Coordinate family visits provided they can follow safety procedures for essential visitors:

- ✓ Screening prior to entry
- ✓ One visitor at a time
- ✓ Follow PPE protocols
- ✓ Maintain physical distancing from resident

Safekeeping of Resident Deceased Personal Belongings

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

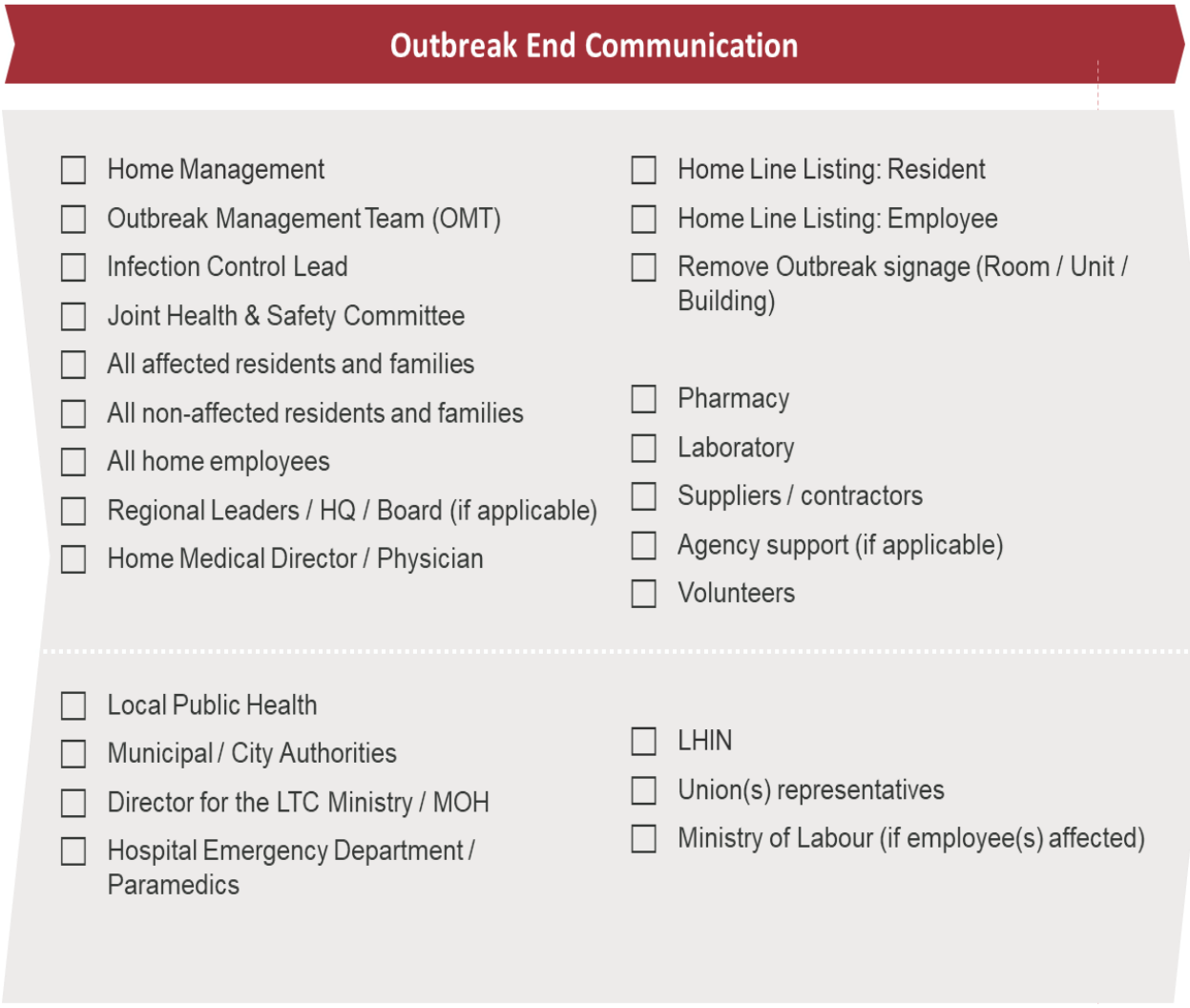
- ✓ Verbal consent will be acquired by the POA/family member to box up the belongings as visitor restrictions may be in place.
- ✓ Housekeeping/maintenance staff will pack the resident's belongings while creating a list of items packed and will sign off on the list – verifying the contents. A copy will be provided to the POA/Family member, and a copy retained by the

Home.

- ✓ The families will be advised of the need to pick up belongings as soon as possible.

When the Outbreak is Over

	Declaring Outbreak over	Done
1	In collaboration with local PHU, outbreak may be declared over when there are no new cases in staff after xx 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 staff 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 staff to review outbreak management and capture lessons learned. Update relevant documentation.	



Investigate & Review the Outbreak Management

Outbreak Management Meeting

At the meeting review the following:

Investigate the Outbreak

An investigation file should be created to review the following:

- ✓ Copies of laboratory and other pertinent results
- ✓ Copies of all meetings minutes & pertinent communication
- ✓ Any other documentation specific to the investigation

Review the Pandemic Outbreak

Meet with local public health unit & community partners to review what all happened:

- ✓ What was done well?
- ✓ What hurdles did the Home face?
- ✓ What lessons were learned?

- ✓ What documents/checklist or policies may need to be revised?

Submit the report to the infection control committee with a copy to the LTCH's (if not done by OPH) and CEO.

Physiotherapy service

Physiotherapy service is essential during a pandemic and Physiotherapy services will be provided with all precautionary measures to prevent the spread and to enhance the quality of life of residents in LTC. PT/PTAs work according to the guidelines they receive from the government &CPO during Pandemic.

Physiotherapists continue to provide "urgent care" during a pandemic.

Even with the directions, each physiotherapist assesses the risks vs benefits criteria for providing physio during pandemic, Hold or STOP care as needed and follows the Ontario government and Public Health Ontario's advise on safe to resume care.

Essential / Urgent care includes assessment and therapeutic intervention or services for conditions or situations where not receiving physiotherapy services (whether in-person or virtually) would put the patient's safety at risk, or there is potential for significant harm or significant adverse patient outcomes.

During Pandemic physio services are provided with avoiding multiple floor visits/day and visiting the Outbreak units at the end of the day/session to limit contacts. Physio department follows advise from DOO & GC IPAC team regarding using equipment, hot packs, bringing Residents on bike etc.

During pandemic physiotherapy service will be provided following the changing guidelines & directives from the Government, public health, Ministry, CPO & GC policy & procedure.

Area for Isolation, new admission and transfer

When making decisions on areas for isolation, admissions, discharges, transfers, and absences, the Glebe Centre will adhere to the MOLTC Act and Regulations, as well as any Public Health guidance on Infection Prevention and Control.

Appendix A: The Person Behind the Mask

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

Let's Remember:

Due to the ongoing concerns related to COVID-19, Residents with dementia may experience increased anxiety and/or confusion while they're in quarantine. Residents are currently isolated from family, friends and loved ones due to current visiting restrictions which may be impacting their mental health and ability to socialize with others.

In addition, for the safety of both Residents and health care workers, the use of Personal Protective Equipment (Such as Masks) may limit or hinder the ability for Residents to connect with their health care workers. Existing behavioral and psychological symptoms may be heightened, and these Residents may be at a greater risk of developing new or progressing Responsive Behaviors 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 whiteboard 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 & athome. It is important for Staff to look after their own Physical & Mental Health during these times.

Thank you for all that you do!

Appendix B: Donning & Doffing PPE

Appendix C: Supplies and Equipment Checklist

Supplies and Equipment		
Category	**Item**	**#**
Hand Hygiene	Liquid Soap	
	Alcohol Hand Rinse/Sanitizer	
	Paper Towels	
Personal Protection Equipment	Surgical/Procedure Masks	
	N95 Masks	
	Yellow 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	
	Garbage bags	
	Autoclave and other specialized waste disposal bags	
	One-use tissues	
	Garbage Cans	
Respiratory Care	Oxygen tubing	
	Nasal prongs/cannula	
	Oxygen masks – low concentration (simple O2 masks,venture masks)	
	Portable oxygen tanks	
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	
Incontinence	Briefs, pads, wipes	

Appendix D: Home Preparedness Checklist

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

Have possible modified /changed roles been reviewed & discussed with bargaining units			
What training will outside agencies, volunteers are given if needed in facility? Job action sheets?			
Has staff received education and training on pandemic issues?			
Have staff support systems been discussed i.e., child care, transportation, meals etc.			
Education & Training			
Who will conduct any required training?			
Are there shortened versions of orientation, job routines etc. available for role changes?			
Outbreak education has been reviewed with all staff – i.e., what signals an outbreak			
Resident Care			
Services that could be maintained or enhanced have been identified			
Services that could be reduced or eliminated have been identified			
Resident essential care needs are current on care plans			
Anti-virals / Vaccines			
Does the facility have adequate capacity to store anti-virals & vaccines			
Have Residents who are to receive anti-virals been identified?			
Which Residents are to receive vaccines?			
Are resident medical directives and consents current to allow rapid administration of meds?			
Is there a plan for screening of staff & visitors?			
The facility is aware of required reporting forms and has sufficient quantitiesreadily available to staff for i.e., Public Health etc.			
Support for Visitors/Families/Volunteers			
How will the facility handle increased numbers of visitors wanting entrance to the facility or who want to remove Residents from the Home?			
Who will handle family concerns?			
Supplies			
Has a list of supplies been identified for resident care, environmental, etc. x1 month			
Have suppliers been contacted re abilities to supply items during a pandemic?			
Can local suppliers provide medical equipment if needed?			
Have back-up suppliers been identified?			
Has the facility pharmacy provider been contacted to review facilities needs?			
Security			
There is a lock down system in place for controlled entrance & existing of building			
Lock down system has been tested			

Is there an alternative system available besides facility lockdown to secure? access points?			
Relocation of Residents			
Has the physical layout of the facility been reviewed to identify natural isolation areas for Residents if such an area and move is needed?			
Is there a temporary location identified in case evacuation of the facility is required?			
Has a meeting occurred with local Hospital re: either transfer of Residents to the Hospital or to receive patients from the Hospital?			
How will Residents be moved to temporary locations?			

Appendix E: Initial Pandemic Outbreak Meeting Template

Pandemic Outbreak Committee Members: Tel 613-238-2727

Position	Committee Member's Names and contact
Chief Executive Officer	Emma Tibbo ext 303
Medical Director/Attending Physician	Doctor Schneider 613-614-9493 (see current on call list)
Director of Care	Emily Osewe Ext 308
Infection Control Manager	Sanja Deric ext 379
Food and Nutrition	Victoria Ucer 331, Adrian Kusuma ext -502 Angela Argyracopoulos ext 361
IPAC Supervisor	Kulwinder Kaur ext 516
Director of Environmental Services/Supervisor	Rod Way ext 313, Carolyn Herfkens ext 493
Director of Operations	Susan Zorz ext 323
Director of HR/HR Assistant	Diane Giusto ext 312 Gloria Torres ext 497
Quality and Risk Manager	Kinjal Joshi ext 315
Nurse Practitioner	Chris White ext 317
Nurse Educator	Lucinda Burklen ext 371
Pharmacy Consultant	Pharmacist
Manager of PSW/Nursing	Pat Van Bregt ext 345
Physiotherapy Services	Sheeja Varghese ext 373
Health and Safety	Rod Ext 313 Staff representative RN
Union Representatives	Gorrett Ponte ext 496 , CUPE President
Bio Test Lab	Asif and Annik Turgeon Laboratory Manager T: 1-800-409-1942
Public Health Representative	613-580-2424 ex 26325
Director Building Architecture	Jake Milne- Smith ext 376
Social Worker	Oluwatoke Afolabi ext 491
Residents representative	Resident

Chairperson: coordinating team meetings & delegating tasks:

Primary : Emma Tibbo Alternate: Susan Zorz/ Emily Osewe

Recording Secretary: taking meeting minutes and distribution:
Primary: Heidi Fluegel Alternative: Oluwatoke Afolabi

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

Primary: Sanja Deric Alternate: Kulwinder Kaur

Media Spokesperson: responsible for responding verbally or in writing to all Media

Inquiries: Primary: Emma Tibbo / Susan Zorz Alternative: Emily Osewe

Person Responsible for anti-viral order: Doctor / Nurse Practitioner /Nursing

Anti-viral medication is stored in the Medication room 3rd floor Monkwood /Medication dispensing Cabinet.

Public Health Representative must be invited to all meetings

Command Centre location: 2nd floor -Gathering place

Main pandemic bulletin board location: In the Elevator

Shortened job action sheets for each dept. located: Nursing station

Screening Location & Documents: Classroom 1st floor

Infection control surveillance forms binder location: 2nd floor – CEO office entrance and reception

Meeting Agenda:

Agenda Item	Person Responsible
Case Definition:	IPAC Manager
Signage – What is needed and where to post?	ES/DO
Specimen Collection – How, what Residents, when, and how often?	IPAC/ Nursing
Communication Plan: - Internal - External	CEO/Communication Lead
Staff Education/ Training – Any needed?	Nurse Educator
Daily Communication with PHU: Line list updated, time to call	IPAC/Nursing
Review of required PPE/Control Measures – Type, where set up	IPAC/ES
Frequency & Time of Outbreak Meetings:	CEO
Revise the IPAC preparedness plan, evaluation of the IPAC plan	IPAC/QIR

Appendix F: Daily High Touch Cleaning Checklist

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

Environmental Services – Disinfect the following area twice daily:

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

Appendix G: Examples of High Touch Items and Surfaces

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

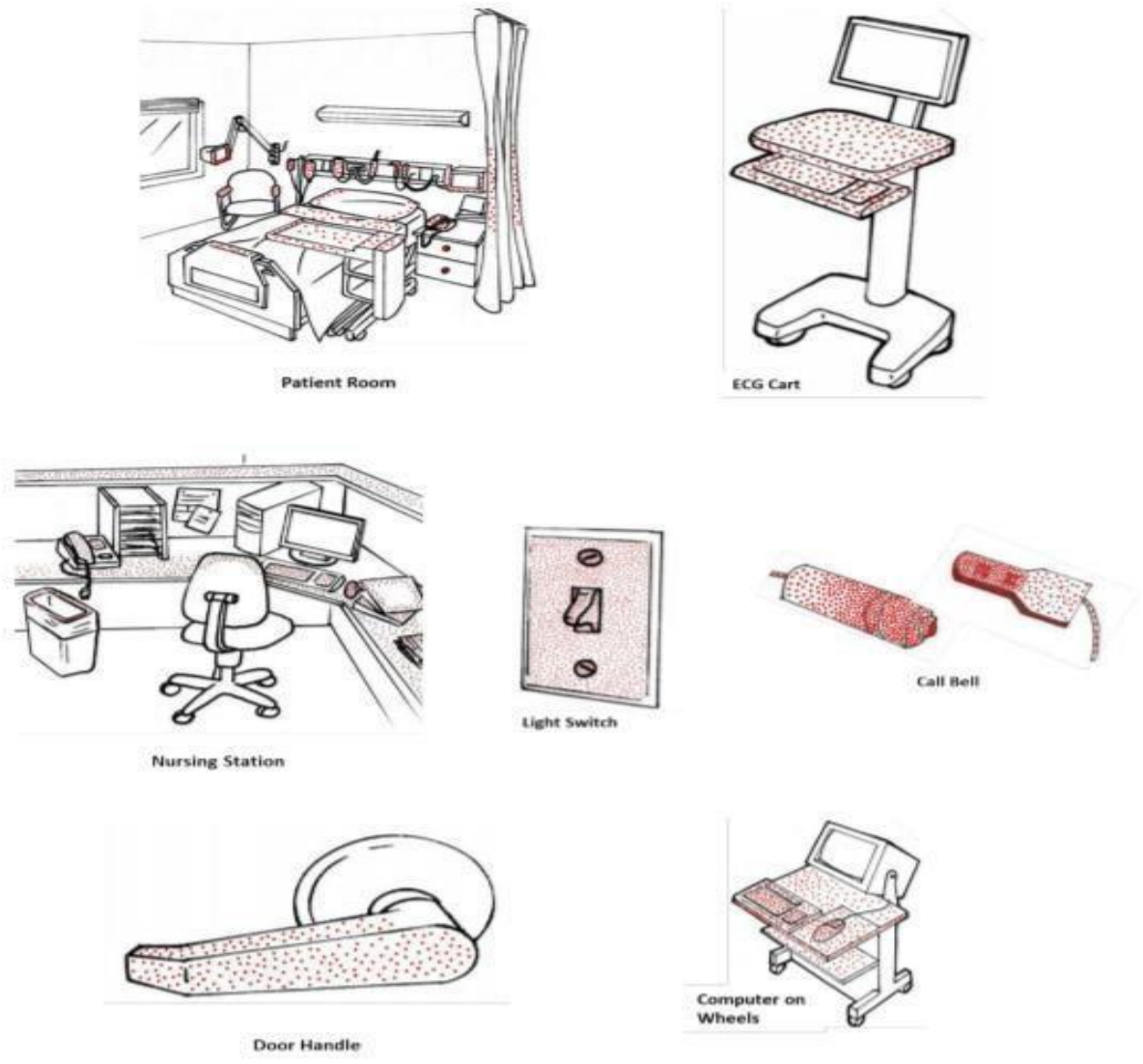


Figure 3a: Examples of High-Touch Items and Surfaces in the Health Care Environment
(Note: Dots indicate areas of highest contamination and touch)

Appendix H: Laundry Audit

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

Appendix I: Four 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.

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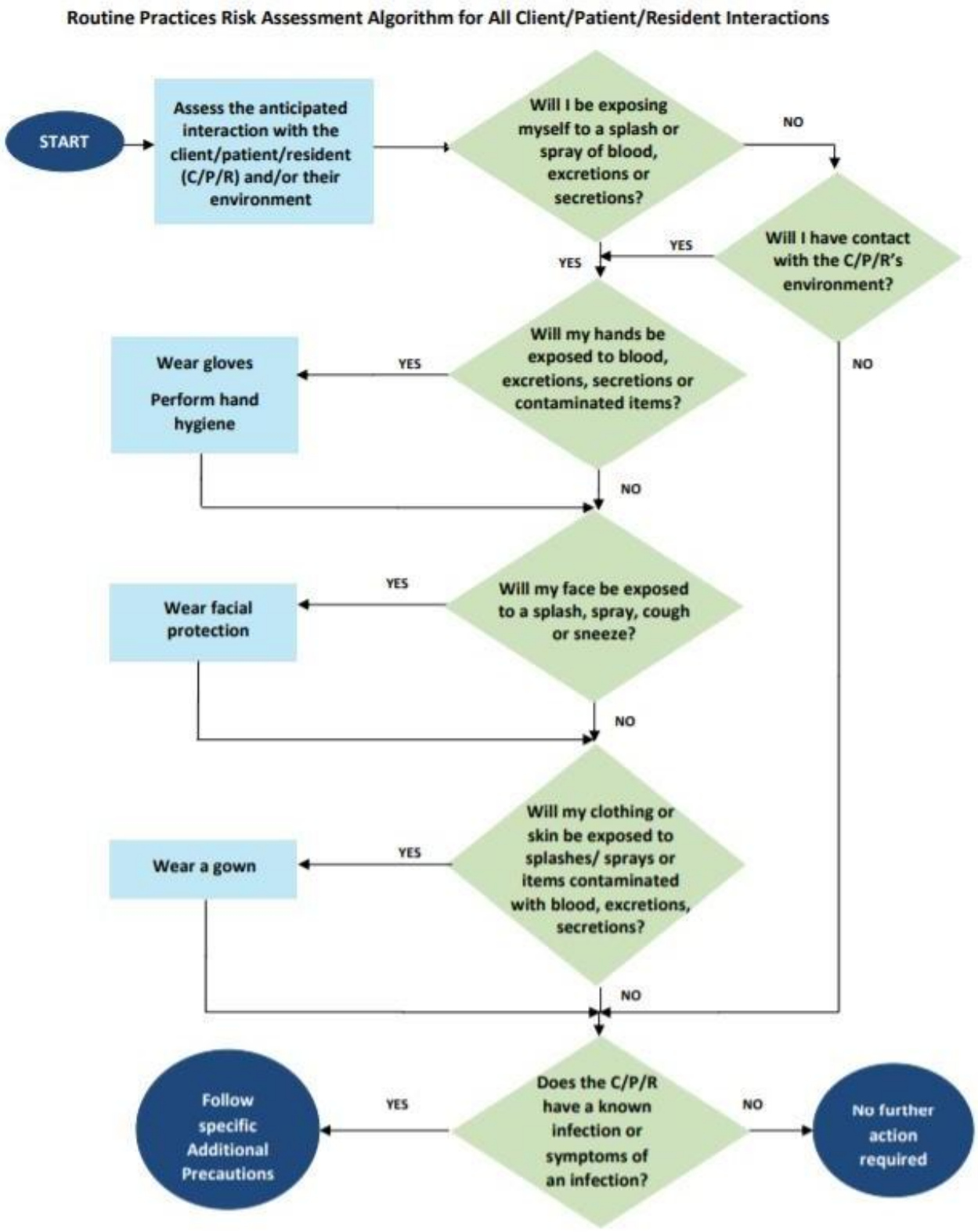
Appendix J: Routine Practices Risk Assessment Algorithm



STEP#	AREA	TIMELINE	ACTION	MRP
1.	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, and daily case reporting)	LTC Home
			• Proactive monitoring and screening of residents, staff, and visitors, including essential caregivers for risk Testing for staff and visitors, as per Ministry direction • Ongoing training and auditing on IPAC protocols, including cohort contingency planning, and access to personal protective equipment • 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 • All testing kits are available	LTC Home
			• Clarify roles and responsibilities for local partners (OH Regions, IPAC Hubs, Home and Community Care Support Services (HCCSS)) • Convene and coordinate regional/local partnership tables • Regularly monitor key indicators as part of the risk identification and collaboration processes	OH Regions
2.	Communication and Notification 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 System or 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 the home • 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 Protection and Promotion Act (HPPA) to address communicable disease prevention/control issues e.g., enforce IPAC protocols	PHU
			• Implement communication plan, including notification to residents; and families, regarding outbreak protocol and visiting policies; staff, including daily emails on key updates; and acute care hospitals regarding possible transfers • Provide information/lists of staff, visitors, and residents, including those cohorted/isolated to PHU for contact 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 Outbreak Management Team after outbreak is declared by PHU • 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	Most Responsible Organization to be identified locally
			• MLTC inspections deployed where necessary, and based on risk assessment • Monitor daily statistics for outbreak management	MOLTC

			• Provide regulatory oversight of the emergency response to determine policy instruments that may need to be actioned (e.g., mandatory management order, voluntary management contract)	
4.	Outbreak Management	Within 24 hours of a confirmed case	• Contact tracing, follow-up, and case reporting • Coordinate home outbreak testing strategy in accordance with the 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	(PHU, IPAC Hubs and MLTC)
			• Initiation of LTCH's on-going outbreak management processes (work occurring beyond scope of this document)	LTC Home in collaboration with MLTC, PHU, IPAC Hubs, Hospitals and OH Regions
5.	Oversight	On-going	• Monitoring of recovery efforts	MLTC LTC Corporate offices

Appendix K: Communication Plan

Stakeholder	Method	Purpose	Frequency	Responsibility
The Glebe Centre Care Operations Team	Risk Alert Email	Communicate the declaration of an outbreak	Upon initial outbreak notification fromOPH	Chief Executive Officer Director of Operations Director of Care Director Environmental Services
Residents	In-person	Communicate information that istimely – home in outbreak and casecounts	As required	Home staff (TBD)
Resident Council	In-person	Communicate information that istimely – home in outbreak and casecounts	As required	Director of Operations
Family Council	Email Letter Phone call	Communicate information that istimely – home in outbreak and casecounts	As required	Director of Operations
Family Members/POA	Email Phone call	Communicate information that istimely but not resident-specific, case counts	Daily	Director of Operations
Family Members/POA	Phone call	Clinical Communication: Resident Positive Case, Update on residents change incondition	As required	Nursing Team
Staff	Email, POC Bulletin board Screening Desk	Communicate information that istimely	Daily or as required	IPAC Manager

JHSC & Union	Email Letter	Communicate information that istimely – home in	As required	IPAC Manager
	Phone Call Written Notices of Staff Cases	outbreak and case counts		
Family members/POA/ Community	Website and social media updates	Communicate information that istimely	Daily or as required	Communication and Change Lead
Family Members/POA and Residents	Virtual Calls- IPAD Phone	Resident & Family Communication	As required	Ward Clerk/Activities staff/modified staff
Media (all media requestsfor comment go to Glebe)	Email, phone call, video conferencing	Communicate information that is timely/ respond to requests	As required	Director of Operations
Initial Outbreak CorporateCall	Teams Call	Ensure all IPAC protocols are in place, determine priority and frequency of calls, review any supportsneeded	24 hours afterthe outbreak declared	Set up by Communication and Change Lead. CEO assistance, attended by outbreak management team
Priority Outbreak Corporate Calls	Teams Call	Review Status of outbreak and review of supportneeded	As determined byoutbreak priority	Set up by Communication and Change Lead. CEO assistance, attended by outbreak management team
Potential Town Halls	Teams Call Phone Call	Communicate information that is timely/ respond to requests, questions	As requested	CEO

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):

Appendix L: Long-term Care Contingency Plan for Resident Care

	Routine Services At baseline to 10% below baseline	**Non-Critical Services Reviewed/ Optional** 11-25% below baseline	**Non-Critical Services Optional** 26-50% below baseline	**Critical Services Only** More than 50% below baseline
Safety				
Passive / Active Screening	√	Utilize the after-hours process to allow redeployment to resident care within scope	Utilize the after-hours process to allow redeployment to resident care within scope	Utilize the after-hours process 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, G tube)	√	√	√	√
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 passes and number of medications Medication optimization	Consult with Pharmacy and MD/NP to prioritize medication for chronic/acute pain management, insulin dependent diabetes, essential medication, and treatment for chronic disease management. Identify pharmacy technicians to assist as required	Consult with Pharmacy/MD to prioritize medication for chronic/acute pain management, insulin dependent diabetes, cardiac issues. (Assign other treatments, i.e., vital signs)
Respond to acute medical events	√	√	√	√
Medical appointments	√	Routine appointments if operationally able Consult with MD/NP to identify and prioritize medically essential appointments	Routine appointments if operationally able Consult with MD/NP to identify and prioritize medically essential appointments	Routine appointments if operationally able Consult with MD/NP to identify and prioritize medically essential appointments
Medical investigations (lab, x-ray)	√	Consult with a lab to identify priority routine investigations and medically essential investigations	Consult with a lab to identify priority routine investigations and medically essential investigations	Medically essential investigations only
Physician Assessment	√	√	In-person assessment preferred but can be done virtually	In-person assessment preferred but can be done virtually
Care of Resident				

Hydration and nutrition	Regular meals x3 Snacks, including hydration x 2 provided	Regular meals x3 Snacks optional (unless diabetic or supplementary nutrition included as part of care plan) Shift to tray service from dining room service if needed in affected areas Hydration provided	Regular meals x3 Snacks optional (unless diabetic or supplementary nutrition included as part of care plan) Shift to tray services in affected areas Hydration provided	Regular meals x 3 Shift to tray services & consider catered meals Diabetic snack and ordered supplementary nutrition Hydration provided
Assistance with meals	√	Review seating plans to group residents together who require assistance or monitoring with meals Identify those who have Essential Visitors in place for support at mealtimes Look to Students/Volunteers for support	Residents seated together in groups for monitoring and assistance if still doing dining room services Delegate monitoring and pottering to alternate providers (i.e., Housekeeping, Activity) Assistance with meals delegated to care team and leaders especially if transitioned to tray service Essential Visitors to aid specific residents per established care plan Alter staff break schedules around resident peak mealtimes Look to Students/	Ratio of staff: resident to assist with meals may be decreased Residents seated together in groups for monitoring and assistance if still doing dining room service Delegate monitoring to alternate providers (i.e., RSA, Housekeeping, Activation) Assistance with meals delegated to care team (i.e., HCA) Essential Visitors to help specific residents per established care plan Alter staff break schedules around

			Volunteer for support	resident peak mealtimes Look to Students/Volunteer for support
Personal Body Washing	Complete bath or shower twice per week as per Care Plan Consider dry shampoos, bathing 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 Visitors in place for support with personal washing/ADLs	Peri-care, hand and face washing, bed baths Essential Visitors to provide assistance with personal washing/ADLS to specific residents per established care plan	Peri-care, hand, and face washing Essential Visitors to help with personal washing/ADLS to specific residents per established care plan
Dressing Always be aware of resident dignity	In own clothes/pajamas	Clothes/pajamas, changed as needed	Resident 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, change incontinence product as needed Identify residents at high risk for skin integrity issues and prioritize	Frequency may be decreased, Identify residents at high risk for skin integrity issues and prioritize Consider reprioritizing tasks, i.e., bed bath so incontinence product can be changed as a priority over bed	Frequency maybe decreased, maximize time in brief Identify residents at high risk for skin integrity issues and prioritize Consider reprioritizing tasks, i.e., bed bath so incontinence

			baths	product can be changed as a priority over bed baths
Bowel Care	√	√	√	√
Wound care	Per Wound Care Plan	Complex wound management, consult with ET nurse or wound care product supplier for Wound Care Plan/products that maximize time between dressing changes	Complex wound management, consult with wound care nurse or wound care product suppliers for Wound Care Plan/products that maximize time between dressing changes	Complex wound management, consult with wound care 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 their wheelchairs and out of bed as able. For Lifts: Effort should be made to try to maintain this during the outbreak Identify & prioritize those residents requiring a mechanical lift – Review opportunities to decrease	Frequency may be decreased Priority given to those who are unable to turn/change position without assistance and those who need to be up in a chair/wheelchair due to skin/wound issues and to support cognitive orientation. For Lifts: Develop schedule which includes a reduced number of transfers i.e. Out of bed every 2/3 days – and a positioning schedule in place.	Frequency may be decreased Priority given to those who are unable to turn/change position without assistance. For Lifts: residents remain in bed with a turning and positioning schedule in place
Palliative/End of life Care	√	√	√	√
Essential Visitors	√	Review Essential Visitor plans and maximize care provided by Essential Visitors	Essential Visitors for identified care needs	Optimize Essential Visitors for identified care needs
Care planning				

Kardex	√	√	√	√
Interdisciplinary Care Plan	√	Review acuity of residents to prioritize care needs and assignments with staff available	Review acuity of residents to prioritize care needs and assignments with staff available	Review acuity of residents to prioritize care needs and assignments with staff available
Care Conference	√	Optional - priority to complex residents or admission care conference	Optional - priority to complex residents or admission care conference; explore virtual option	Virtual option
Behavioral Care Planning	√	√	√	√
Assessment				
Falls	√	√	√	√
Pain	√	√	√	√
Behavior/Cognition	√	√	√	√
Monitoring of skin integrity	√	Frequency decreased to bathing schedule, priority given to residents at medium or high risk	Assessments of high-risk pressure areas	Only if clinically necessary Priority should be given to immobilized residents
Routine weights and vitals	√	Routine measurements may be deferred to another shift, priority to clinically necessary measurements	Only if clinically necessary	Only necessary for acute event
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 with clinical need Staff may be reassigned to mandatory duties within their scope of practice	Essential clinical need only Staff reassigned mandatory duties within their scope of practice
Social Work	√	Review residents and identify priorities including those at risk to social isolation and without any family members.	Priority work only (Support, complete adult/ guardianship investigations, time sensitive documents per licensing; checking in on the most socially isolated residents) May be redeployed to assist with resident care as directed within scope	Priority work only (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 activities when available Consider shifting to 1:1 programming with focus on those at greatest risk of social isolation	Review programs, identify high attendance, low staff demand activities Maximize use of HCSWs for activities when available Off-site outings optional Staff may be redeployed to assist with resident care as directed within scope	Review programs, identify high attendance, low staff demand activities Maximize use of HCSWs for activities when available Off-site outings cancelled Staff may be redeployed to assist with resident 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 Director of Care RAI staff can be utilized to provide clinical care	Priority to full assessments only Observation period may be adjusted until staffing is yellow or green & escalate to Director of Care. RAI staff can be utilized to provide clinical care
Admissions				
Admissions	Based on current directive	Based on current directive	Cancel until complement is yellow or green	Cancel until the staffing complement is yellow or green

Appendix M: 24 Hour Outbreak Checklist

To be completed with first 24 hours of outbreak

ACTIONS TO BE COMPLETED	Date and Initial when completed
Clinical – Nursing	
If possible, move confirmed resident to a private room • Immediately, place on additional precautions • Isolate and follow Public Health directions as per length of isolation	
If sharing a room: PPE to be used for all "Close Contact" residents. • PPE to be doffed and new PPE donned in between residents in the shared same room. • Curtains are always closed and designated commode chairs in the shared bathroom. • Follow Public Health directions if testing is required.	
Set up PPE equipment caddy prior to entry to the resident room(s) (Isolation cart, Precaution signage, Don/Doffing Signage, Garbage can, Individual linen bin, ABHR, ensure PPE station and garbage/dirty linen are not beside each other.	
Ensure N95 Masks are available and used by staff, list of staff mask fit available on public drive	
Document the finding on the Public Health line listing form	
Document assessment in resident health record for all care provided	
Complete and document vital signs in progress notes/PCC	
Increase resident screening as directed by Ministry of Public Health	
Review and update the care plan	
Resident education on precautions in place.	
Perform testing on all suspect cases and roommates as directed by Public Health	
Cohorting of staff to care for residents; Where possible separate staff caring for symptomatic/ high-risk contacts, otherwise care completed after well residents.	
Daily cleaning and disinfection of resident equipment (i.e., wheelchair, walkers, cane)	
Assign nursing equipment for individual resident use if possible (thermometer, O2, etc.)	
Notifications – Nursing/Designate	
Post outbreak signage at entrance to unit including stairwells	
Inform team members working in the unit of confirmed and probable residents if roommates involved.	
Education training done on PCRA, HH, PPE, donning, doffing, care procedures required, i.e., AGMP's such as medications that require aerosol require N95 respiratory	
Ensure all PPE including N95 Masks are available to staff (Charge RN to oversee)	
Inform the MD/NP/Attending Physician of confirmed case	
Notify Public Health; implement outbreak protocols as directed by Public Health. Follow Infection Prevention & Control measures for Outbreak Management.	
Notify POA of all residents involved.	

Review Advanced Directives with POA's and MD as required.	
Notify Manager on call	
Notifications – CEO/DOC	
If outbreak is declared by the PHU **(suspect or confirmed**) during business hours (Mon -Fri 8:00am-4:00pm) the home must immediately report to the Ministry by submitting a Critical Incident System (CIS) form	
If the PHU (suspect or confirmed) declares outbreak after hours, the home must: - Call the after hours reporting line at 1-888-999-6973 and - Complete a CIS form first thing the following business day	
Notify all other departmental managers/directors	
Notify external health providers who service residents (nursing, cleaning, private companion, essential caregivers, hairdressing etc.)	
Update staff and POAs using email/ PCC, IPAC board	
Initiate daily huddles with staff to provide education, updates, current practices and procedures and post meeting minutes	
Determine Managers schedule to provide daily support in the homes including weekends	
Post information about the outbreak and safety information on the IPAC board in the elevator/ entrance	
Hold huddles on every outbreak units at report	
Post all new directives and policies on the board	
Implement outbreak staff assignment sheet and post for staff to help support working assignments/cohorting including up staffing where needed for cohorting.	
Determine if 1:1 or security is need for residents who wander or may be non - complaint with isolation/IPAC protocols- if possible	
Initiate MOL list if staff cases	
Cleaning – Housekeeping	
Cleaning of resident room for confirmed and any probable roommates – schedule as the last room(s) to clean and disinfect	
Increase cleaning and disinfectant to the entire unit/floor to twice/day Follow the cleaning policies and Procedures. Recommend using high-level disinfectant	
Increase cleaning of all high-touch surfaces to the home	
Ensure cleaning products are well stockpiled	
Ensure cleaning for high-touch carts, heavy equipment etc.	
Laundry – Nursing/Care Attendant	
If personal Laundry is done by family, individuals will require screening upon entering the residence.	
Disinfect laundry carts	
Meals – Nursing/Care Attendant/Dietary	
Tray service for suspect and confirmed outbreaks	
Use disposable items for residents on tray service.	

Appendix N: Interdisciplinary Meeting

The interdisciplinary infection prevention and control team meets quarterly and on a more frequent basis during an infectious disease outbreak in the home; and the local medical officer of health appointed under the Health Protection and Promotion Act or their designate is invited to the meetings (s.102(4)(a)-(d) of the Regulation).

Resources

- Health Protection & Promotion Act

  (HPPA) - 1990
- Fixing Long-Term Care Act, 2021, S.O 2021, c. 39, Sched. 1 (ontario.ca)
- Respiratory Infection Outbreak - Long-term Care (interiorhealth.ca)
- Ministry of Health & Long-Term Care- Recommendations for the Control of Gastroenteritis Outbreaks in LTCHomes – March 2018
- Ministry of Health & Long-Term Care - Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, 2024
- Ontario Government – Vaccine Fridge Storage and Handling Guidelines – May 2013
- Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes
- Just Clean Your Hands – Long-term Care | Public Health Ontario