The Glebe Centre

IPAC

Emergency Preparedness Plan

Updated in collaboration with the OPH

March 2023

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Purpose of Plan

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

Goal of Plan

↘To reduce the spread of virus/contagion among residents, staff, family members and volunteers.

↘To maintain essential care and services for residents during a pandemic in order to keep ↘them in the Home.

↘To ensure that workplace health and safety standards are maintained to support staff, families and volunteers in meeting resident care and service needs.

Understanding the Difference between Pandemic and Outbreak

Pandemic	Outbreak

An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people. Global pandemic — one that has spread over several countries or continents affecting a large number of people.	A number of cases that exceeds what would be expected. The case definition in an outbreak is dependent on the presenting signs and symptoms and circumstances. It may vary between outbreaks and also vary during an outbreak. **COVID-19:** Two or more residents with a common epidemiological link (e.g., floor/unit) each with a positive molecular test OR rapid antigen test result (RAT), within a 10-Day period. **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: **Suspected Gastroenteritis Outbreak** Definition Two suspected cases of infectious gastroenteritis in a specific area, such as a home, unit, or floor within 48 hours. **Gastroenteritis Outbreak Definition** Three or more cases of infectious gastroenteritis in a specific area within a four-day period, or three or more units/floors having a case of infectious gastroenteritis within 48 hours. Note: This definition may be modified as the investigation proceeds. **Confirmed Respiratory Infection Outbreak:** • Two cases of acute respiratory infections (ARI) within 48 hours with any common epidemiological link (e.g., unit, floor), at least one of which must be laboratory confirmed; OR • Three cases of ARI (laboratory confirmation not necessary) occurring within 48 hours with any common epidemiological link (e.g., unit, floor). **Suspect Outbreak Definition***Suspect respiratory infection outbreak: • Two cases of ARI occurring within 48 hours with any common epidemiologic link (e.g., unit, floor); OR • One laboratory-confirmed case of influenza.

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 Homes. Please note that all these policies apply until they are reversed. When new guidance involves significant change, ensure this document is updated (including updates tracking), and communicate the change with stakeholders impacted by the change.

Da	Description	Source

t e		
January , 2023	COVID-19 guidance document for long-term care in Ontario	Best Practices for Managing COVID-19 Outbreaks in Acute Care Settings (publichealthontario.ca)
January ,2023	LTC Pandemic Response Update	Best Practices for Managing COVID-19 Outbreaks in Acute Care Settings (publichealthontario.ca)
January, 2023	COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes	COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (gov.on.ca)
December , 2022	COVID-19 Vaccine – Staying Up-to-Date	COVID-19 guidance document for long-term care homes in Ontario | ontario.ca

Prevention and Preparedness

Preparedness

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

Screening

An active screening process is in place upon entry to the home. Screening is performed by a screener, we are also using a screening app C-screen. Individuals entering the home are

screened and visits are logged at all times. The screener should keep a distance of two meters (6 feet) from all individuals entering. If this is not possible, the screener is required to wear personal protective equipment (PPE) per their personal risk assessment. The screener actively screens all visitors, with the exception of emergency first responders, following current Ministry of Health screening criteria. They also provide education on hand hygiene and masking to all visitors. Staff or visitors who fail screening are not permitted entry into the home and instructed to either get tested, if eligible, or speak with their supervisor (for staff). Actively screen all residents upon returning from an absence for signs and/or symptoms of COVID-19. The table below outlines some steps/processes to consider when implementing a screening program:

Number #	Screening	Note
1.	Individuals entering the facility should be screened, following current Ministry of Health screening criteria. Entry cannot be granted without screening. The screener must: Ask about symptoms, provide a new mask and make sure HH is done *please refer to screener check list (Appendix A) Ask about potential close contact with symptomatic or infected individuals* Anyone who does not pass a screening will not be allowed to enter, should self-isolate and contact their managers. Note: Emergency first responders and Ministry should have permitted entry without screening.	
2.	Designated screener is at the door at 0730-1930, after hours' to be screen by a nurse	

3.	All Residents are to be screened for COVID-19 symptoms twice daily when in outbreak**,** once daily when not in outbreak, including temperature checks. Log in PCC (or template if PCC not used).	
4.	If visitor have been instructed to quarantine by public health officials, they will be instructed not to visit The Glebe Centre. If visitors are experiencing signs and symptoms of COVID-19, they will be instructed not to visit Any individual who has tested positive for COVID-19 must wait 10 days before coming into the home	
5.	Screener must wear at a minimum mask, eye protection, and have access and use alcohol-based hand rub	
6.	Failed Screening: Isolate / Do not allow to enter the Glebe**.** Staff will be screened as per ministry guidelines.	

Passive Screening & Signage

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 at each room Visual reminders to perform point of care risk assessment (PCRA) prior to any resident interaction (recommend having at med carts, nursing stations,computers)	

2.	**Signage at entrances:** • Indicates building access directives • 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	
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	

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 physicaldistancing:

- Avoid handshakes
- Avoid crowded places and non-essential gatherings
- Limit contact with people at higher risk
- Keep 2 m physical distance

Swab Clinic and Testing

- All staff, students, volunteers and Essential Caregivers (ECGs) who are “up to date “with a COVID-19 vaccine are required to complete 2 Rapid Antigen Tests (RATs) in a 7-day period (Monday-Sunday)
- All staff, students, volunteers and ECGs who are not “up to date” with the COVID-19 vaccine are required to complete 3 RATs in a 7-day period (Monday-Sunday)
- General Visitors and Support Workers are required to complete a RAT each time they visit and wait for results.
- Rapid Antigen Testing requirement may be initiated daily if the Home is on outbreak, or as per OPH directive

Working from Home

Who Should Work from Home?

The Home should make every effort to facilitate work from home where possible to limit the number of people on site who could potentially bring in the disease. However, this cannot come at the cost of quality of care or 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 Operations Team
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., hold tablet from room to room). Physicians may still come on site where needed but should limit contact to aminimal 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.
Role	**Recommendations**
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 staffcan be redeployed (e.g., to environmental services)
Environmental	Staff performing environmental duties (cleaning and disinfection, laundry,waste management) cannot work from home
Dining	Staff performing dining duties (cleaning and disinfection, laundry, waste management) 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 Homes may need to implement staff contingency plans in order to complete the essential care and services required for Residents.

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 be repositioned • Follow outbreak management policies • Advanced care planning will be followed and updated as required	

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 careand interactions. A PCRA will help determine the correct PPE required to protect the health care worker intheir 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.

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

Cohorting: Group Residents based on their outbreak status or risk of symptoms during an outbreak. Cohorting is a way to help prevent the spread of infection within the facility. Where possible, and in accordance with other requirements of the facility, cohorting should be done by keeping resident on the same unit.

Staff Cohorting: Having a staff member look after only one cohort of Residents and not moving from one cohort to another during a shift.

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

Staff and Resident Cohorting

Our Home have 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.

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
- Work flow should be organized so care to 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 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 other at 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 infection control program 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
- 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

1.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

×Facilities will maintain active surveillance using the local Public Health surveillance forms.

2.Pandemic Activity in the Home

When an outbreak of the Pandemic strain is suspected or confirmed in the Home,

the Home will take 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) Implement control measures for visitors
12)When the outbreak is over- done by OPH
13) Investigate & review the outbreak

Steps Involved – Pandemic Activity in the Home

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

×Notify the local authorities by phone about the potential or confirmed outbreak

×Submit the outbreak reporting forms to CIS, Ministry of Labor, Health and Safety and unions representatives

×Report the initial control measures that have been implemented

×Review with the local Public Health Unit – If any and which Residents are to be tested, 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 management of the Glebe

2.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** :The ministry recommends (but no longer requires) caregivers and visitors to wear masks when they are alone with a resident in their room. When not in a one-on-one setting with a resident in their room or a designated space within the home, visitors and caregivers are required to be masked.	COVID-19 guidance document for long-term care homes in Ontario | ontario.ca
3.	All staff should have undergone **N95 fit** testing	
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 on resident.	
6.	Garbage can 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 PPE use (e.g., screening with morning care).	
8.	Assess **PPE** requirements based on resident touchpoints.	
9.	Procure a minimum of **14-day supply of PPE** on an ongoing basis. In prevention, PPE levels are recommended to be sufficient for 14 days of outbreak measures in one unit. Once in outbreak, procure 14-day supply for all units in outbreak.	
10.	Implement process for **tracking of PPE availability.** Keep count of PPE levels in storage and update as supplies are restocked/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 face shield and gown. All staff should be trained on donning and doffing procedures as outlined below, and signage should be placed near donning/doffing stations to remind staff of steps. Regular audits and refresher training should be performed throughout a pandemic. Refer to Appendix D 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 Residents (extended use). Masks should be changed when soiled, or when moving between COVID-19 positive/suspected Residents and other Residents. Except when deemed necessary during PCRA	
Eye Protection	As long as eye protection is not soiled, wet or dirty, it can be worn to provide care to several Residents (extended use) – note that eye protection is generally not required when not in outbreak. Eye protection should be changed when soiled, or when moving between positive/suspected Residents and other Residents. Reusable eye protection requires no extended use measures – it should always be washed and disinfected between uses. Some disposable eye protection may be reused, but should be reused by the same staff member and washed and disinfected between uses (recommend writing names of staff on shield in permanent marker). 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.	

Note: these are not standard practices for PPE and should not be used 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 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 Appendix K for 4 Moments of hand hygiene).

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

Vaccination

COVID-19 vaccination is one of the most effective ways to help prevent severe illness and death due to COVID-19. We encourage residents, staff, caregivers and visitors to remain up-to-date with their COVID-19 vaccinations. Vaccination is offered at home most of the time on a monthly basis. New admissions to our home, who are not up-to-date with their COVID-19 vaccinations should be offered a complete series of a COVID-19 vaccination, or their remaining eligible doses, as soon as possible. For more information on the COVID-19 vaccine and resources available refer to Ontario's COVID-19 Communication Resources page. Residents may also be eligible for the influenza, pneumococcal, tetanus, zoster and diphtheria vaccines in accordance with Ontario's publicly funded immunization schedule. Publicly Funded Immunization Schedules for Ontario (gov.on.ca)

Admissions and Transfers

As per section 5.1 of the LTC Minister's Directive, LTCHs shall ensure that the detailed requirements and information related to admission and transfer into the home, including requirements for testing and isolation, are followed as set out in this guidance document. Admissions and transfers are permitted when the home is not in an outbreak and the resident is not on additional precautions due to symptoms, exposure, or diagnosis of COVID-19 to minimize the risk of infection transmission. Admissions and transfers to a home in an outbreak and/or involving a resident who is on additional precautions may be considered in partnership with the local Public Health Unit (PHU). Any resident being admitted or transferred, regardless of their COVID-19 vaccination status, who is identified as having symptoms, exposure, and/or diagnosis of COVID-19 must be self-isolated and placed on additional precautions at the Home and managed as per the Management of Cases and Contacts of COVID-19 in Ontario in addition to the requirements below. All residents who are being admitted or transferred to a home must undergo screening regardless of their COVID-19 vaccination status. The resident is not required to isolate if they pass screening and are asymptomatic. Refer to the LTC Ministry website at COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units (gov.on.ca) Please refer to Appendix E: Algorithm for admissions and transfers for LTCHs and RH in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units

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 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 J, 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 during the pandemic times Policies and procedures regarding staffing in Environmental Services departments should allow for surge in waste (e.g., additional PPE).	
2.	Ensure that 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 waste from one bin to another • Never reach into, or 'push' on the bag, to push the garbage down • Carry the garbage bag away from your body (hold bag by the knot/ties)	

	If the bag of garbage is heavy and/or there is a chance the bag may break or leak, use a double/bag method 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.	Work with HR to support employee morale	

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

Individuals to Contact	Contacted
Medical Director/Attending Physicians/Nurse Practitioners	
Homes Management Team – ED, 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	

4.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 oras instructed by authorities; Executive Director or designate to

activate team.

Outbreak Team Initial Meeting

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

- Assignment of key roles – Chairperson, Secretary, Outbreak Coordinator, Media Spokesperson
- Develop working case definition
- Determine appropriate signage is posted to notify visitors of outbreak status and to remind staff 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 G, Initial Pandemic Outbreak Meeting Template

5.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

Refer to Appendix J, COVID-19 Outbreak Tracking Form

6.Implement Control Measures for Residents

Resident Appointment, Vacations, and Hospital Transfers:

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

#	Resident Absences	Completed
1.	Residents are **permitted to leave the Home** for short-term absences,vacation, appointments (e.g., visit family or friends), for prescribed medical reasons (e.g., dialysis, transfusions, etc.).	
2.	If a resident leaves the Home for an **outpatient visit or hospital transfer**, the Home must encourage resident to wear medical mask if they tolerate it.	
3.	When a resident return: • Screen resident before entry to the facility • Provide them with a mask • Bring them directly to their room • Put in appropriate precautions if needed • Isolate in room for XX day if required • Request tray service • Screen for day 5 post-arrival Note: : Asymptomatic testing is no longer recommended for COVID-19 surveillance except for roommates of positive covid-19 cases.	
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 family if resident is to be transferred to hospital.	
6.	Patient transfer services should not be used to transfer a suspected or confirmed case.	

Transfer to Hospital will be required if:

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

Criteria for Resident Relocation

If a resident has been determined eligible to go Home with family members, the registered staff, in conjunction with the DOC, will provide support, education, medication and personal care items to support the transfer Home. This will not be considered as a discharge to community unless the family/resident wishes a permanent discharge.

7. Implement Control Measures for staff and volunteers/ Human Resource management

Policies to Consider

In the event of a pandemic, labor legislations (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 to their normal duties unless specific directions are otherwise given. The use of volunteers, students, and family members to assist in the provision of residentcare 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 O, Critical

Staffing/Resident Care Contingency Plan for OLTCA. The DOC/designate will maintain the list of cross trained staff.

Staff Support Services

In conjunction with the Homes ED, 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 issuesas well as general mental health.

Resources	Notes	Contact
EAP	Excising Corporate EAP	HR department
ConnexOntario OntarioMental 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=JK4X K83AYC
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.abilitiCBT.co m/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 – Sharing Information

It is the expectation that in the event of an influenza, COVID19 or any other pandemic, that the Joint Occupational Health and Safety Committees, (JOHSC) and the Union Representatives may request more frequent meetings to review potential staffing changes, PPE requirements, policy changes, 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 whenthe 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 WSIB.

× All staff request for work accommodations should be discussed with the WSIB Coordinator.

Recreation

The Recreation team plays an essential role in ensuring resident wellbeing and morale throughout the pandemic. While most typical activities are suspended, Recreation 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 to remain in isolation can include outside/window concerts.	
6.	If possible, capture photos / videos of Residents to share with family Note: Prior consent from resident and family may be required, and staff should not use their personal device to record images of Residents.	
7.	Work with HR to support staff morale.	
8.	Continue with all activities listed in the prevention section unless otherwise indicated below.	
9.	As per most recent ministry guidance activities can continue if there is a suspect or confirmed covid-19 outbreak. In some cases PHU may recommended these activities be discontinued.	

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:

× Each facility must ensure they have a designated cold chain storage location monitored by a temperature log to ensure viability of vaccine

× The vaccine fridge must maintain temperatures in the range of 2-8 degrees Celsius

× The vaccine fridge temperatures will be monitored q2times 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 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 initiated and communicated to all staff. IPAC manger/designed will post information on PCC and on the Infection Control Board in elevator. The IPAC team/nurse will communicate pandemic information and updates obtained at the team meeting to their staff via the following:

Huddles on 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 to volunteer to assist during a pandemic (i.e., screener). The Registered Staff on each unit is responsible for contacting and responding to family’s questions regarding a health status of the resident.

Information about the pandemic and the Homes actions will be shared with Resident, 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 7-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. The ED and FNM will determine the frequency of the stock rotation. Refer to Appendix E Supplies and Equipment 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	

8.Implement Controls for Visitors

Visitor Management

As with any outbreak visitor restrictions are likely to be out in place and may be directed/mandated by legislative bodies. The restriction of visitors may be a necessary requirement during the pandemic to prevent the spread of the virus/contagion to our most vulnerable population. 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 residentand 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 localpublic health unit or telehealth for further instruction. If any visitor becomes upset or has further questions, staff should contact a manageror 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 pandemiccontagion	
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).	

9. End of Life Care

The Office of the Chief Coroner may provide direction to Homes on the management of deceased Residentsduring 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 orthe 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 consultedfor information and guidance.

Visitors at End of Life

Visitors are allowed into the Home for Residents that are nearing the end of life. Determining a resident is at end of life, is informed by a discussion with the doctor. The IPAC team or nurse on the unit provides guidance to staff at the Main Entrance to inform them of the residents formally deemed end-of-life. If a resident is receiving end-of-life care, non-vaccinated/partially vaccinated Essential Caregivers (ECGs) and general visitors can be allowed entry into the home. Visiting is restricted to the resident's room. Coordinate family visit 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:

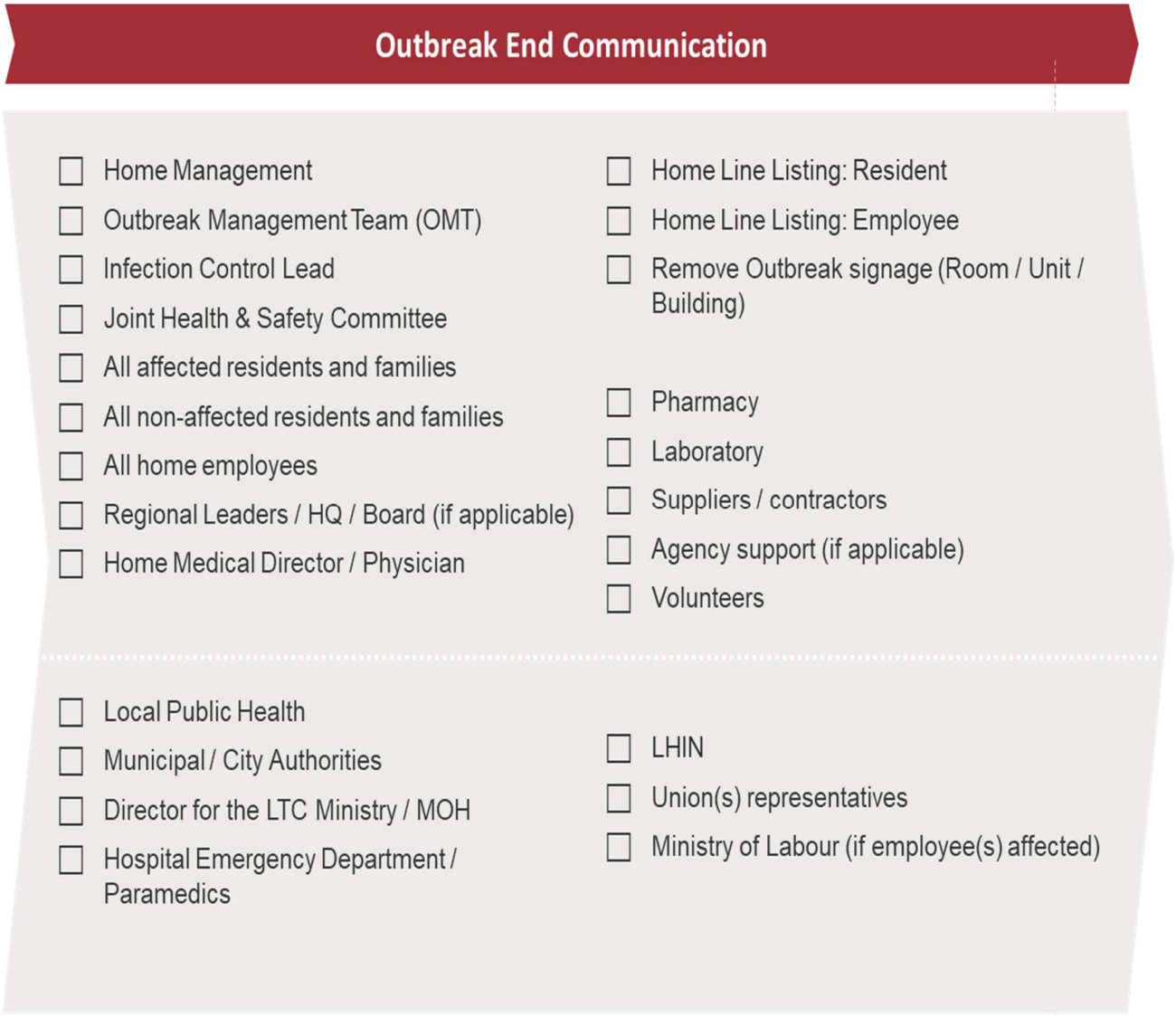
× Verbal consent will be acquired by the POA/family member to box up the belongings as visitor restrictions may be in place.

× 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 copyretained by the Home.

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

10.When the Outbreak is Over

#	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.	



11. Investigate & Review the Outbreak Management

1. Meeting

At the meeting review the following:

1. **Investigate the Outbreak** – An investigation file should be created to review the following:
    a. Copies of laboratory and other pertinent results
    b. Copies of all meetings minutes & pertinent communication
    c. Any other documentation specific to the investigation

2. Review the Pandemic Outbreak
    a. Meet with local public health unit & community partners to review what all happened:

i. What was done well?
ii. What hurdles did the Home face?
iii. What lessons were learned?
iv. What documents/checklist or policies may need to be revised?

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

Physiotherapy service

Physiotherapy service is essential during pandemic and Physiotherapy services will be provided with all precautionary measures to prevent the spread of Covid 19 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 pandemic.

Even with the directions, each physiotherapist assess the risks Vs benefits criteria for providing physio during pandemic, Hold or STOP care as needed and follow the Ontario government and Public Health Ontario 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 Out break 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

According to the New LTC Act ,2021, COVID-19 guidance document, "Areas for Isolation" are now required in LTC Homes in Ontario. Furthermore, subsections 102(9) and 269 (1) of O.Reg 246/22 state that all homes must meet IPAC requirements and have an emergency management plan for any type of disease outbreak, as well as an area of the home that could be used for isolation if the need arises.

Glebewood - North wing rooms 206-213 have been designated as the Glebe Centre's isolation area.

When making decisions on 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 Job Tasks – COVID-19 Door Screener

Back to text

1. Upon entering work area – Sanitize your hands
2. Don (put on) Personal Protective Equipment (PPE) in proper order unless behind Plexiglas; in whichcase you require a mask only: (a) gown (b) mask (c) shield (d) gloves
3. Prepare Station – Disinfect - Look to see you have all your supplies in adequate amounts
   a) Visitor Screeners – make sure you have enough sheets printed
   b) Sanitized pens
   c) Hand Sanitizer
   d) Disinfectant Wipes
   e) Masks – gowns – gloves
   f) Garbage can
4. As Staff/Visitors enter – ensure Social Distancing – 6 feet minimum – if screening in a confined area –
   only two person allowed in at a time.
5. Before Screening starts – have Staff/Visitor**:** Sanitize Hands, put on mask.
   Ask Staff/Visitor Screening Questions LTCH RH Screening Tool - English (gov.on.ca)
6. Make sure visitor and contractor sign the log book. The visitor log must include, at minimum, the name and contact information of the visitor, time and date of the visit, and the purpose of the visit (e.g., name of resident visited). These records should be maintained for a period of at least 30 days the Visitor S
7. Sanitize pen between each use or have “clean” and “dirty” containers for pens.
8. Allow staff/visitor to enter Home area if they have passed screening and RAT (Rapid Antigen Testing)
9. Staff/Visitors are NOT to be screened when leaving for the day

NOTE: During your shift – you are to be consistently wiping your area – includes: door handles, automaticdoor buttons, furniture and any other high touch areas.
If a delivery is made- call the nurse on the floor for a pick up
DON’T LEAVE screening station un-attended.

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

Ensure Entrance is Locked

Appendix B COVID-19 Screener Audit Tool

Facility:_____ **Date/Time:**_____

Auditor: _____ **Name of Screener:** _____

1. There is a screener present at the entrance to **actively** screen all HCWs, other staff, and visitors (indoor, essential, non-essential, etc.) as they enter the building?
   YES, NO N/A
2. Active screening procedure occurs from 0530-1930, seven days a week? YES NO N/A
3. Hand Hygiene completed by each individual upon entry to home? YES NO N/A
4. Screening questions are read out loud by the screener to each individual who wishes to enter the building (i.e. if the individual do not have the C- screen app)?
   YES NO N/A
5. Staff and visitors (indoors and outdoors) are screened daily? YES NO N/A
6. There is a process to record who has entered and exited the home? YES NO N/A
7. There is a process to identify type of visitor and record of their name, contact info, resident they are visiting and in/out time?
   YES NO N/A
8. The screener is wearing appropriate PPE (a mask, eye protection)?
   YES NO N/A
9. There is hand sanitizer with 70-90% alcohol concentration at the screener table/entrance? YES NO N/A
10. All staff and visitors perform hand hygiene prior to putting mask on? YES NO N/A
11. Masks are available to staff and visitors at the entrance for donning upon entry to the home? YES NO N/A
12. PPE (masks, eye protection, gowns, gloves) available for staff or visitors who require full PPE? YES NO N/A
13. Signage/posters present for how to don and doff PPE, proper hand hygiene, etc.? YES NO N/A
14. Is physical distancing taking place and is there signage promoting physical distancing? YES NO N/A

15. PPE doffing station available at the screener table (for screener or visitors who need to wear the full PPE)? YES NO N/A
16. **Results:** *If "Yes" to all questions, circle compliant. If any answers were "No", circle Non-Compliant. Non-Compliant - Action Plan: If non-compliant – record what action was completed in order to ensure compliance.*

Appendix C 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 white board to communicate information.
- ☐ Consider using communication cards with words/pictures of any tasks.
- ☐ Consider using appropriate non-verbal cues including gestures demonstrating what you are asking of the Resident (i.e., helping the person to dress or bringing them a meal.
- ☐ If the Resident has questions surrounding precautions or PPE, provide simplified explanations.
- ☐ If communication is not going well for you or the Resident, stop what you are doing (as long

as the individual isnot at risk) and re approach at another time when you/the individual have de-escalated

- Even though you are wearing a mask, continue to smile as this may change your tone.

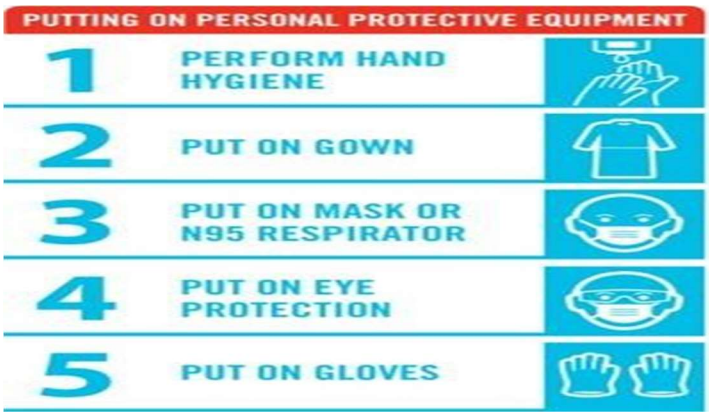
BSO Psychogeriatric Resource Consultant (PRC) Team, April 2020 (Adapted from Caitlin Reidy, BSO BIS)

Reminder for Self-Care:

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

Thank you for all that you do!

Appendix D Donning & Doffing PPE
Back to text



Appendix E Supplies and Equipment Checklist back to text

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 F 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?			

Task	Yes/No	Action	Date Completed
Has staff received education and training on pandemic issues?			
Have staff support systems been discussed i.e., child care, transportation, meals etc.			
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 quantities readily 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. x 1 month			
Have suppliers been contacted re abilities to supply items during a pandemic?			
Can local suppliers provide medical equipment if needed?			
Have back-up suppliers been identified?			
Has the facility pharmacy provider been contacted to review facilities needs?			
Security			
There is a lock down system in place for controlled entrance & existing of building			
Lock down system has been tested			

Task	Yes/No	Action	Date Completed
Is there an alternative system available besides facility lockdown to secure? access points?			

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 G Initial Pandemic Outbreak Meeting Template back to text

Pandemic Outbreak Committee Members: Tel 613-238-2727

Position	Committee Member's Names and contact
Executive Director	Lawrence Grant ext 303
Medical Director/Attending Physician. NP	Dr Gerd Schneider
Director of Care /MNCO	Ankica Jovan ext 349 / Brenda Paul ext 308
Infection Control Manager	Sanja Deric ext 379
Food and Nutrition	Victoria Ucer 331,Adrian Kusuma ext -502 Angela Argyracopoulos ext 361
Outbreak Surveillance Supervisor	Marley Walker ext 364
Director of Environmental Services/Supervisor	Rod Way ext 313, Carolyn Herfkens ext 493
Director of Operations/HR/ Quality Management	Susan Zorz ext 323, Barbara Duggan ext 312, Maha El Bahkiry ext 315
Pharmacy Consultant	Michael Guest
PSW Supervisor	Debbie Wyllie ext 345
Physiotherapy Services	Sheeja Varghese ext 373
Health and Safety	Suja Thomas ext 501
Union Representatives	Gorrett Ponte ext 496 , Candice Chaloux ext 377
LAB	Asif
Public Health Representative	Chyril Smith 613-580-2424 ex 26325
Building System Coordinator	Jake Milne- Smith ext 376
Residents representative	Pollonetsky Abigail

1. **Chairperson**: coordinating team meetings & delegating tasks:

   Primary: Lawrence Grant Alternate: Susan Zorz/ Ankica Jovan

2. **Recording Secretary**: taking meeting minute taking and distribution:

Primary: Heidi Fluegel Alternative: Harmandeep Kaur

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

Primary: Sanja Deric Alternate: Marley Walker

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

   Inquiries:Primary: Lawrence Grant/ Susan Zorz Alternative: Barbara Duggan /

   Ankica Jovan

5. Person Responsible for anti-viral order: Dr Schneider / Nurse Practitioner /Nursing

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

6. MOH Representative must be invited to all meetings

7. Command Centre location: 2nd floor -Gathering place

8. Main pandemic bulletin board location: In the Elevator

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

10. Screening Location & Documents: Classroom 1st floor

11. Infection control surveillance forms binder location: 2nd floor – ET office entrance and reception

12. Meeting Agenda:

Agenda Item	Person Responsible
Case Definition:	Sanja Deric
Signage – What is needed and where to post?	NURSING / IPAC champ
Specimen Collection – How, what Residents, when, and how often?	IPAC team/ Sanja
Communication Plan: - Internal - External	Susan /Barbara/Lawrence
Staff Education/ Training – Any needed?	Sanja/ IPAC Champ
Daily Communication with PHU: Line list updated, time to call	Sanja//nurse in charge
Review of required PPE/Control Measures – Type, where set up	Sanja/ / Carolyn /Candice/ Rod
Frequency & Time of Outbreak Meetings:	Lawrence/ Ankica
Revise the IPAC preparedness plan, evaluation of the IPAC plan	Director of Quality Management ,Maha

Appendix H 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 I 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

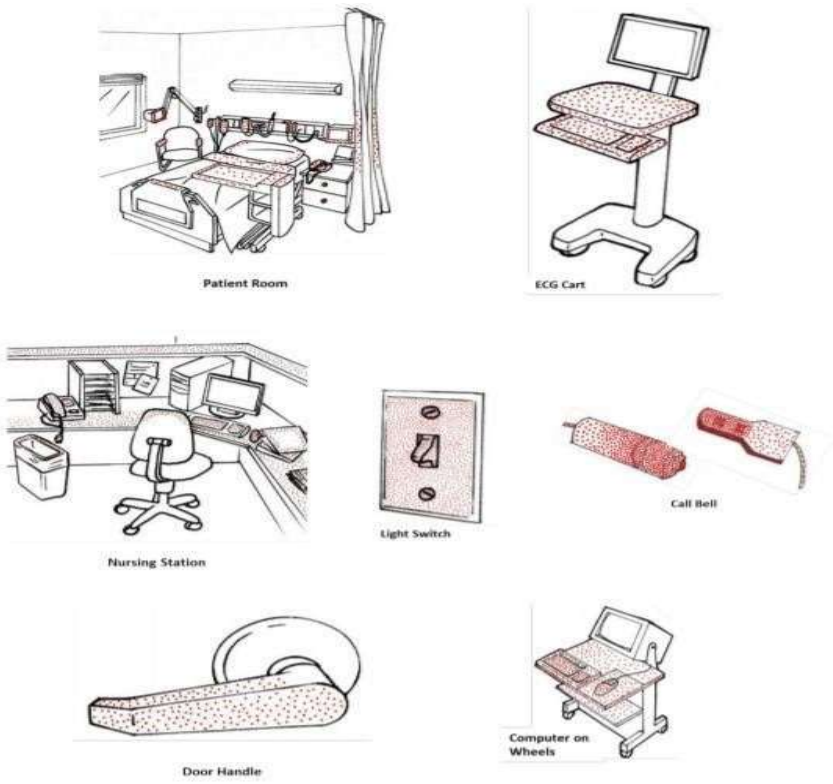


Figure 3a: Examples of High-Touch Items and Surfaces in the Health Care Environment
(Note: Dots indicate areas of highest contamination and touch)

Appendix J COVID-19 Outbreak Tracking Form back to text

Date: Home: Type of O/B: Public Health Outbreak# MOL Notified: Y N

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

Appendix K Cross Trained Staff Template

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

Appendix L Laundry Audit

FACILITY:		DATE	
ITEM	**MET**	**UNMET**	**COMMENTS**
Are carts arriving with soiled linen bags covered and bags tied off?			
Is laundry sorted on carts properly? Linens, Personal Clothing, Incontinent Products			
Is clean & dirty linen kept separated?			
Are procedures for handling isolation linen posted?			
Is there protective equipment available for staff? Gowns, Gloves, Goggles/Shield			
Is PPE worn correctly? Soiled Linen Area: Long sleeve gown, Fluid 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 M 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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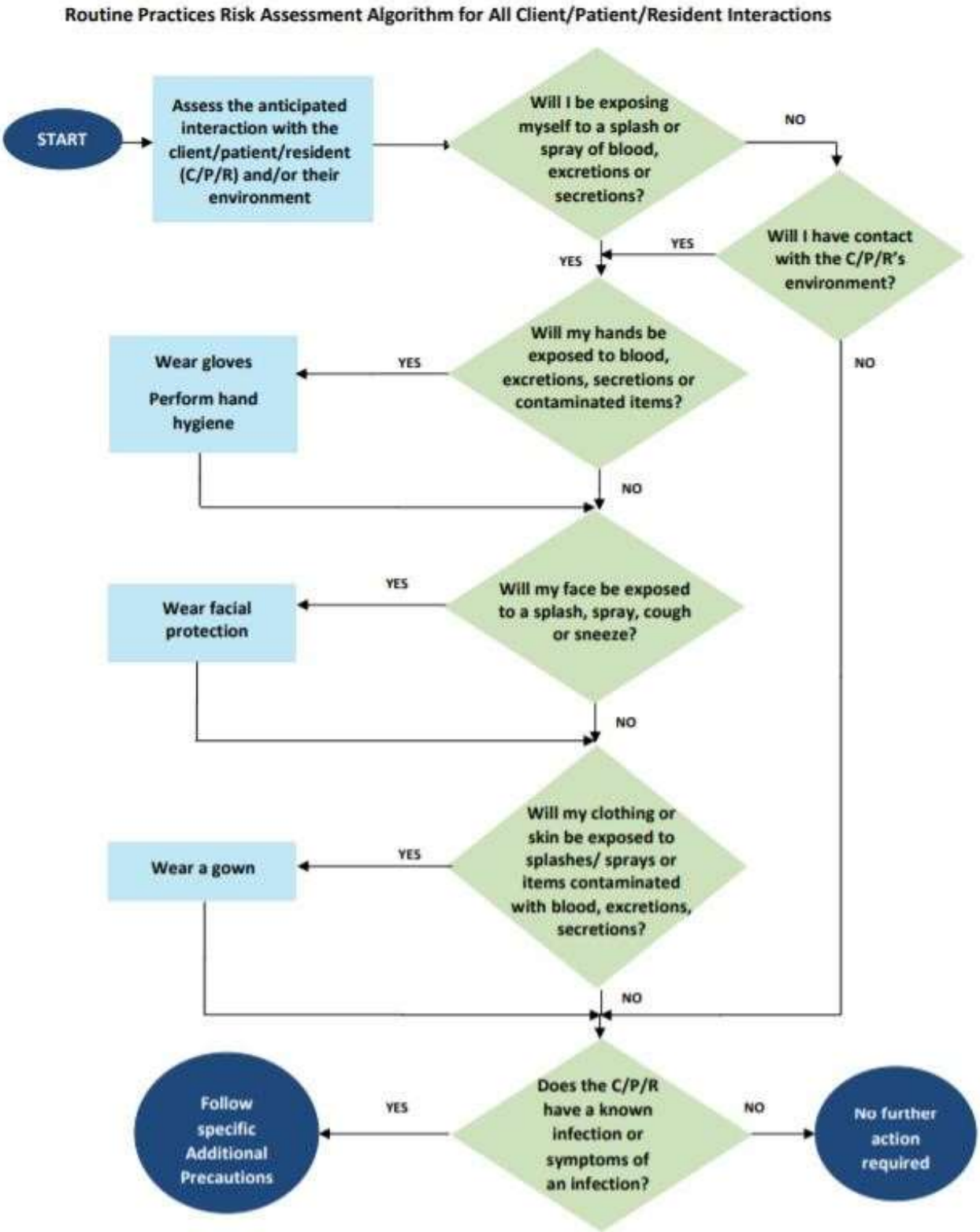
Ontario

Appendix N Routine Practices Risk Assessment Algorithm



Appendix O LCT ONTARIO STANDARD OPERATING PROCEDURES FOR COVID-19 OUTBREAK MANAGEMENT

back to text

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

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

Being Prepared* – LTC Homes Prior to the Outbreak

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

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

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

- Ensure a safe and secure environment for residents (s. 5, LTCHA)
- Effectively prevent and manage outbreaks, including ensuring that there is:
  - An infection prevention and control program for a long-term care home (s. 86, LTCHA)
  - An outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts
  - A written plan for responding to infectious disease outbreaks (s. 229 of O. Reg. 79)
- Ensure that emergency plans are in place for the home that comply with the regulations, including:
  - Measures for dealing with emergencies
  - Procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency (s. 230 of O. Reg. 79/10)

- Ensure there is a staffing plan for its organized program of nursing services and organized program of personal support services (s. 31 of O. Reg. 79/10)
- Follow all other Ministry of Health and Ministry of Long-Term Care direction, guidance related to prevention and management of COVID-19 pandemic
- Ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act. (s. 107 of O. Reg. 79/10)
- Ensure that MLTC Director receives timely, fulsome reports as per the request of the Director pursuant to s.88 of the LTCHA

STEP#	AREA	TIMELINE	ACTION	RESPONSIBLE
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 COVID-19 risk • Regular COVID-19 testing for staff and visitors, as per Ministry direction • Ongoing training and auditing on IPAC protocols, including cohort contingency planning, and access to personal protective equipment as per CMOH Directive #5 • Ensure caregivers are re/trained in PPE techniques • Ensure clinical oversight is in place • Assess residents for transfer, do-not-resuscitate preferences • Maintain accurate records of staff, caregivers, visitors, and families • COVID-19 immunization policy outcomes monitored with individual staff follow up as appropriate ;vaccine maintenance strategy in place (we administer vaccines at our home) • All testing kits are stored on the first floor classroom	LTC Home
			• Clarify roles and responsibilities for local partners (OH Regions, IPAC Hubs, Home and Community Care Support Services (HCCSS)) in the COVID-19 Outbreak Management Team* • Convene and coordinate regional/local partnership tables • Regularly monitor key indicators as part of the risk identification and collaboration processes	OH Regions

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
2.	Communication and Notification of Confirmed Case	Triggered with Confirmed Case	• Dependent on which party receives initial notification of positive results: • If PHU, notify LTCHs; or • If LTCH, report to PHU and immediately notify MLTC via Critical Incident Reporting 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; 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, 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 COVID-19 Outbreak Management Team* (See Section 0) 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	MRO to be identified locally
			• MLTC inspections deployed where necessary, and based on risk assessment • Monitor daily statistics for outbreak management • Provide regulatory oversight of the emergency response to determine policy instruments that may need to be actioned (e.g., mandatory management order, voluntary management contract)	MLTC

STEP #	AREA	TIMELINE	ACTION	RESPONSIBLE
4.	Outbreak Management	Within 24 hours of confirmed case	• Contact tracing, follow up, and case reporting • Coordinate home outbreak testing strategy in accordance with latest guidance/directive	PHU
			• Ensure ongoing cohorting of residents and staff • Subsequent testing, as required based on PHU risk assessment	LTC Home
			• Completion of Outbreak Risk and external IPAC assessments • IPAC extender supports deployed, as needed	(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 P 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	ED/DOC/DO/DES
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	DO(Director of Operation)
Family Council	Email Letter Phone call	Communicate information that istimely – home in outbreak and casecounts	As required	DO /DELIGATE
Family Members/POA	Email Phone call	Communicate information that istimely but not resident-specific, case counts	Daily	DO/Delegate
Family Members/POA	Phone call	Clinical Communication: Resident Positive Case, Update on residents change incondition	As required	Nursing
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 casecounts		
Family members/POA/Community	Website and social media updates	Communicate information that istimely	Daily or as required	Director of Charitable Giving (DCG)
Family Members/POA andResidents	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 istimely/ respond torequests	As required	DO
Initial Outbreak CorporateCall	Teams Call	Ensure all IPAC protocols are in place, determine priority and frequency of calls, review any supportsneeded	24 hours after outbreak declared	Set up by Heidi ED 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 Heidi ED assistance , attended by: outbreak management team
Potential Town Halls	Teams Call Phone Call	Communicate information that is timely/ respond to requests, questions	As requested	ED

Risk Alert Email

Outbreak Declared by Public Health:

Yes, or No Date Outbreak Declared:

Details of the Situation:

What Steps Are Being Taken in the Home to Address:

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

Family Council Letter Sample

To Family Council,

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

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

Initial email Message – Families

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

JHSC Email/Letter Notification

Members of the JHSC, unions

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

As the situation evolves, we will continue to keep you updated. If you have any questions or concerns, please don'thesitate to bring it to our attention.

Voluntary Management Contract

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

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

Appendix R 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 after-hours process to allow redeployment to resident care within scope	Utilize after-hours process to allow redeployment to resident care within scope	Utilize 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/Volunteers for support	Ratio of staff: resident to assist with meals may be decreased Residents seated together in groups for monitoring and assistance if still doing dining room service Delegate monitoring and pottering to alternate providers (i.e., RSA, Housekeeping, Activation) Assistance with meals delegated to care team (i.e., HCA) Essential Visitors to help specific residents per established care plan Alter staff break schedules around resident peak mealtimes Look to Students/Volunteers for support

Personal Body Washing	ɔ bath or shower twice per week per Care Plan sider 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	es/pajamas, changed as needed	nts changed into own clothes and pajamas. change as able	Residents remain in personal night clothing; change as able or soiled
Mouth Care	√	√	Frequency may be decreased	As needed Consider non care staff or essential caregivers assist with mouth care
Toileting	√	Maintain toileting schedules, 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 soincont product can be changed as	Frequency may be decreased, maximize time in brief Identify residents at high risk for skin integrity issues and prioritize Consider reprioritizing tasks, i.e., bed bath so

			a priority over bed baths	incont 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 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	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

			positioning schedule other day	
Palliative/End of life Care	√	√	√	√
Essential Visitors	√	Review Essential Visitor plans and maximize care provided by Essential Visitors	Essential Visitors for identified care needs	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	√	- 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	√	√	√ BSO	√ BSO
Assessment				
Falls	√	√	√	√
Pain	√	√	√	√
Behavior/Cognition	√	√	√	√

Monitoring of skin integrity	√	Frequency decreased to bathing schedule, priority given to residents at medium or high risk	e assessments of high-risk pressure areas	Only if clinically necessary Priority should be given to immobilized residents
Routine weights and vitals	√	Routine measurements may be deferred to another shift, priority to clinically necessary measurements	Only if clinically necessary	necessary for acute event
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 to mandatory duties within their scope of practice
Social Work	√	Review residents and identify priorities including those t great is of social isolation and without any ECGs	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	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

		programming with focus on those at greatest risk of social isolation		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 Regional Director Operations and Corporate clinical lead. 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 Regional Director Operations and Corporate clinical lead. RAI staff can be utilized to provide clinical care
Admissions				
Admissions	Based on current directive	Based on current directive	complement is yellow or green P Ops and Regional Health Authority	ntil staffing complement is yellow or green

Appendix S **24 HOUR COVID1-19 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 COVID-19 resident to a private room • Immediately, place on droplet & contact precautions • Isolate and follow Public Health directions as per length of isolation	
☐ If sharing a room: HRC roommate to be tested on day 5, if negative and asymptomatic can come out of isolation • PPE to be used for all "Close Contact" residents. • PPE to be doffed and new PPE donned in between residents in the same room. • Residents isolating in the same room shall have curtains always closed and designated commode chairs at the bedside. • Follow Public Health directions if testing is required.	
If moving the resident to an isolation room, coordinate with environmental services, if more than one resident move onto same unit in the home where possible	
Set up PPE equipment caddy prior to entry to the resident room(s) (Isolation cart, Precaution signage, Donning Signage, Garbage can, Individual linen bin, Point of Care Risk Assessment, ABHR), ensure PPE station and garbage/dirty linen are not beside each other.	
Set up doffing station inside the resident room by the door (if feasible), having doffing sign posted above garbage (doffing station)	
Ensure N95 Masks are available and used by staff, list of staff mask fit provided to charge nurse	
Document the finding on the Public Health line listing form as well as institutional case and contact form	
Document assessment in resident health record for all care provided	
Complete and document vital signs in progress notes/PCC	
Increase resident screening for COVID-19 to Twice daily on Vitals sheet or PCC, Including temperature.	
Review and update care plan to include interventions for COVID-19 monitoring	
Resident education on precautions in place. Use of COVID-19 Facts Sheets/posted signs on doors and throughout the home	
Perform PCR or RAT testing on all suspect cases and roommates as directed by Public Health	
Cohorting of staff to care for residents ; Staff caring for COVID positive residents will not care for COVID negative residents. Staff caring for positive residents will have their own break areas/change areas. Where possible separate staff caring for high-risk contacts, otherwise care completed after well residents.	
Delay any non-essential appointments for the resident(s) (if fracture, or psych, specialist appointment, look at alternatives such as TEAMs, virtual visits). This includes probable cases sharing the room.	
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 stair wells (if applicable)	
Inform team members working in unit of confirmed and probable residents if roommates involved.	
Education training done on 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 measure for Outbreak Management.	
ACTIONS TO BE COMPLETED	**Date and Initial when completed**
Notify POA of all residents involved Yes No, why not_____	
Review Advanced Directives with POA's and MD as required.	
Notify Manager on call	
Notifications – ED/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 Director by submitting a Critical Incident System (CIS) form	
If the PHU (suspect or confirmed) declares outbreak after hours, the home must: - Call the afterhours reporting line at 1-888-999-6973 and - Complete a CIS form first thing the following business day	
Notify all other departmental managers	
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 including Oxivir, Wipes etc. Order as required.	
☐ Ensure cleaning for high touch carts, heavy equipment etc.	
Laundry – Nursing/Care Attendant	
Personal Laundry done externally/family. Individuals will require screening upon entering the residence. The laundry will be given to the screener in a closed container and disinfected prior to giving to the resident	
Arrangements can be made to bring personal laundry in house. Discuss with Infection Prevention & Control Lead/designate.	
Disinfect laundry carts before sending to non-affected home areas.	
Meals – Nursing/Care Attendant/Dietary	
Move to tray service for the whole home for suspect and confirmed outbreaks	
Use disposable items for residents on tray service.	

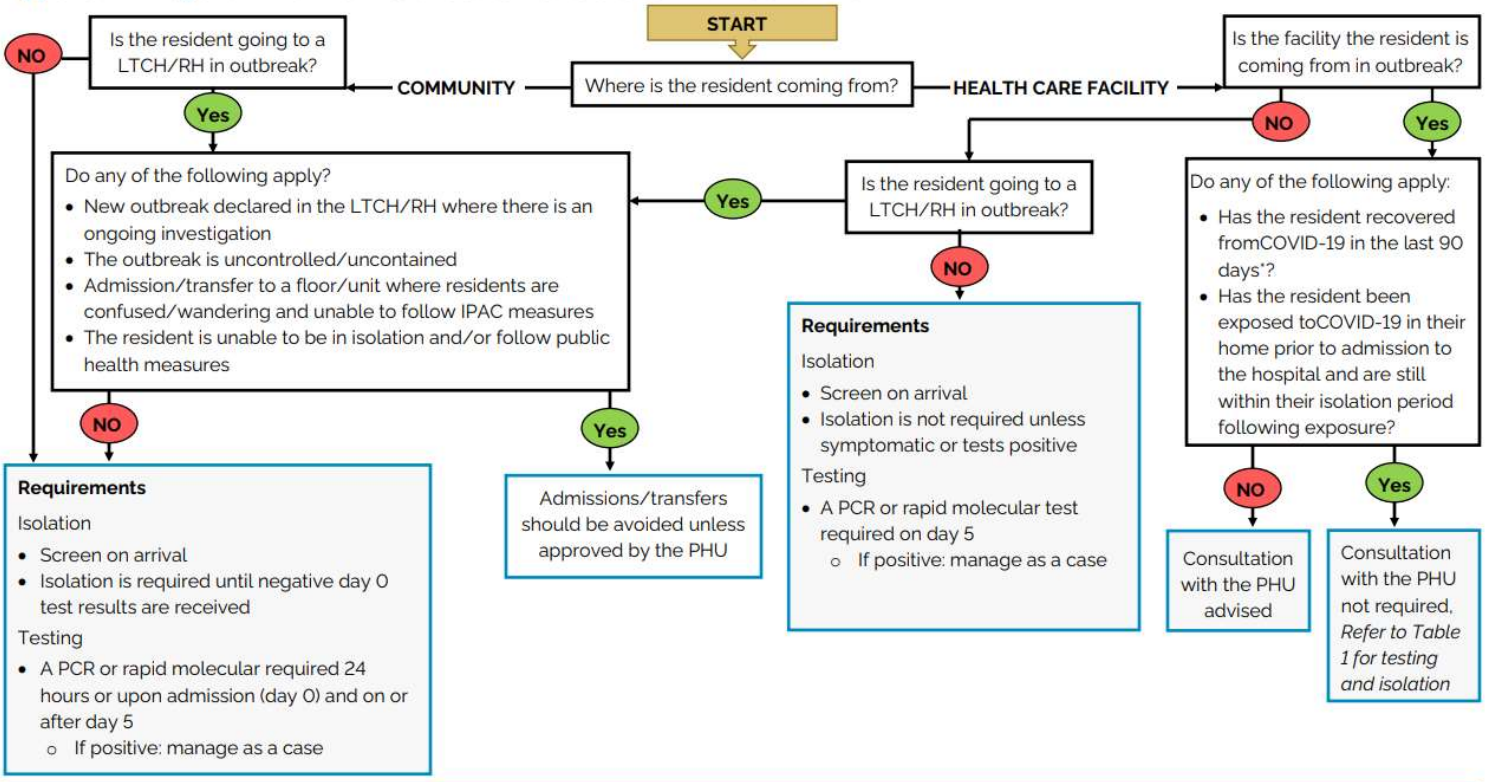
ACTIONS TO BE COMPLETED	Date and Initial when completed
Food Service Operations/ FNM/ Dietary Lead	
☐ Ensure paper product supplies are sufficient for tray service and order as required	
☐ Ensure used trays and cart collection and sanitation process is implemented and educated to staff to prevent cross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

IPAC – INTERDISCIPLINARY TEAM MEETING

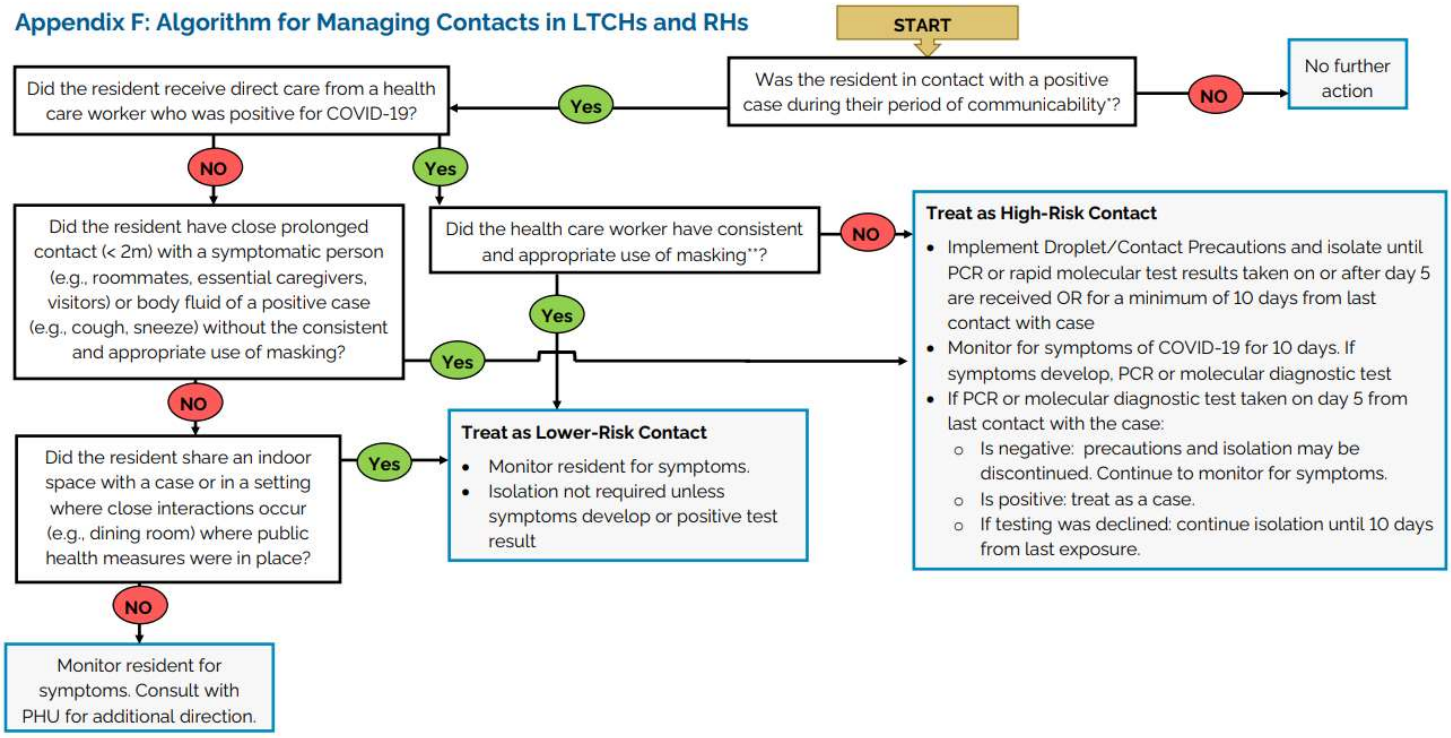
The interdisciplinary infection prevention and control team meets quarterly and on a more frequent basis during an infectious disease outbreak in the home; and the local medical officer of health appointed under the Health Protection and Promotion Act or their designate is invited to the meetings (s.102(4)(a)-(d)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

Appendix T

Appendix E: Algorithm for Admissions and Transfers for LTCHs and RHs



Appendix F: Algorithm for Managing Contacts in LTCHs and RHs



Resources

Health Protection & Promotion Act (HPPA) - 1990

Long-Term Care Pandemic Playbook – June 2020

LTCHA-2007.pdf (longtermcareinquiry.ca)

Fixing Long-Term Care Act, 2021, S.O. 2021, c.

39, Sched. 1 (ontario.ca)

COVID-19: Self-Assessment Audit tool for long-

term care homes and retirements homes

(publichealthontario.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

Ontario Government – Vaccine Fridge Storage and Handling Guidelines – May 2013

IPAC_Standard_for_LTCH_April_2022.pdf (ipac-canada.org)

Just Clean Your Hands – Long-term Care | Public Health Ontario

LTCH RH Screening Tool - English (gov.on.ca)

Optimizing the Supply of Personal Protective Equipment During the COVID-19 Pandemic (ontariohealth.ca)

COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units (gov.on.ca)

COVID-19 Long-Term Care Resources | Public Health Ontario

https://www.ontariohealth.ca/sites/ontariohealth/files/2022-04/Paxlovid-PatientFactSheet.pdf - Antiviral treatment for Covid-19