Infection Prevention and Control Emergency Response Plan

Pandemic, Endemic, Disease of Public Health Significance and associated outbreaks

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Glossary

Acronyms

ABHR	Alcohol Based Hand Rub
ADL	Activities of Daily Living
CNM	Clinical Nurse Manager
COTB	City of Thunder Bay
CSLTC	Community Services and Long-Term Care
DMT	Departmental Management Team
DON	Director of Nursing
ECG	Essential Caregiver
EFAP	Employee and Family Assistance Program
EMS	Emergency Medical Services
ERP	Emergency Response Plan
ESS	Environmental Services Supervisor
H&S	Health and Safety
HCW	Health Care Worker
HR	Human Resources
ICU	Intensive Care Unit
IPAC	Infection Prevention and Control
JHSC	Joint Health & Safety Committee
IV	Intravenous
LTC	Long Term Care
MD	Medical Director
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
MOL	Ministry of Labour
NFS	Nutrition and Food Services
NP	Nurse Practitioner
OMT	Outbreak Management Team
PHO	Public Health Ontario
PHU	Public Health Unit
PIDAC	Provincial Infectious Diseases Advisory Committee
POA	Power of Attorney
PPE	Personal Protective Equipment
PSW	Personal Support Worker
PT	Physiotherapist
PTA	Physiotherapist Assistant
RN	Registered Nurse
RPN	Registered Practical Nurse
SC	Subcutaneous
SDM	Substitute Decision Maker
TBDHU	Thunder Bay District Health Unit
TBRHSC	Thunder Bay Regional Health Sciences Centre
TDQI	Training Development and Quality Improvement
TR	Therapeutic Recreation
WHO	World Health Organization
WSIB	Workplace Safety and Insurance Board

Definitions

Additional Precautions	Interventions implemented to reduce the risk of transmission of microorganisms from resident to resident, resident to health-care worker and health care worker resident.
Biomedical waste	Waste that is generated by human or animal health care facilities, medical or veterinary settings, health care teaching establishments, laboratories, and facilities involved in the production of vaccines (The Canadian Standards Association). May include medical, pharmaceutical and sharps waste.
Cleaning	The physical removal of foreign material (e.g. dust, soil) and organic material (e.g. bodily fluids, microorganisms). Cleaning physically removes rather than kills microorganisms. It is accomplished with water, detergents and mechanical action.
Cohort	A group of people banded together, treated as a group.
Cohorting	Grouping residents based on their risk of infection or whether they have tested positive for a communicable disease in an outbreak. It may also include assigning staff to work with only ill or well residents.
Contact time	The time that a disinfectant must be in contact with a surface or device to ensure that appropriate disinfection has occurred. Refer to the product label for contact time for each individual product.
Contact transmission (Direct & Indirect)	Includes direct contact, indirect contact and droplet transmission as described below: Direct contact occurs when transfer of microorganisms' results from direct physical contact between an infected or colonized individual and a susceptible host (body surface to body surface). Indirect contact involves passive transfer of microorganisms to a susceptible host via an intermediate object such as contaminated hands that are not washed between Residents, or contaminated instruments or other inanimate objects in the patient's immediate environment.
Up staffing	The increase of the core baseline staffing levels based on staffing requirements during a pandemic or an outbreak.
Critical Items	Critical Items are instruments and devices that enter sterile tissues including the vascular system. Critical items present a high risk of infection if the item is contaminated with any microorganism, including bacterial spores. The home only uses disposable critical items such as IV devices.
Daily Attendance Report (DAR)	Tool used to record scheduling changes that occur during the day and then recorded to the schedule through centralized scheduling.
Daily Staffing Assignment (DSA)	A daily department staffing report from centralized scheduling System showing employees scheduled for the day.
Decontamination	The removal of disease-producing microorganisms leaving an item safe for further handling.
Disinfectant	A product that is used on surfaces or medical equipment/devices which results in disinfection of the equipment/device. Disinfectants are applied only to inanimate objects. Some products combine a cleaner with a disinfectant.
Disinfection	The inactivation of disease-producing microorganisms. Disinfectants are used on inanimate objects; antiseptics are used on living tissue. Disinfection usually involves chemicals, heat or ultraviolet light. Levels of chemical disinfection vary with the type of product used.
Droplet	Refers to large droplets, greater than or equal to 5um in diameter, generated from the respiratory tract of the source patient during coughing or sneezing. These droplets are propelled a short distance, less than 1 meter, through the air and deposited on the nasal or oral mucosa of the new host.
Exposure	The condition of being subjected to a microorganism or an infectious disease in a manner that enables transmission to occur.

Hand Hygiene	A general term that applies to hand washing using alcohol hand rinse, antibacterial hand wash or soap and water.
High level disinfection	The level of disinfection required when processing semi-critical items. High-level disinfection processes destroy vegetative bacteria, mycobacteria, fungi and enveloped (lipid) and non-enveloped (non-lipid) viruses, but not necessarily bacterial spores. High- level disinfectant chemicals (also called chemisterilants) must be capable of sterilization when contact time is extended. Items must be thoroughly cleaned prior to high-level disinfection.
Infectious waste	The portion of biomedical waste that is capable of producing infectious disease
Intermediate level disinfection	The level of disinfection required for some semi-critical items. Intermediate level disinfectants kill vegetative bacteria, most viruses and most fungi but not resistant bacterial spores.
Joint health and safety committee	The joint health and safety committee referred to under this plan is not limited to Pioneer Ridge. It includes the Jasper Place supportive housing program as it functions under the oversight of Pioneer Ridge and is included in all aspects of emergency planning.
Low level disinfection	The level of disinfection required when processing non-critical items or some environmental surfaces.
Low-level disinfectant	A chemical agent that achieves low-level disinfection when applied to environmental surfaces, inanimate items, or noncritical medical devices. Low-level disinfectants do not kill mycobacteria or bacterial spores.
Non-critical items	Items that either touch intact skin but not mucous membranes or do not directly touch the resident. These items must be cleaned and disinfected with a low-level disinfectant between residents if multiuse such as stethoscope.
Outbreak	An outbreak is an increase in the number of cases above the number normally occurring in a particular health care setting over a defined period of time.
Outbreak / Non Outbreak Area	An outbreak area is an area that has been declared as in outbreak of a particular illness within the home, this may be a single home area, or multiple home areas. The non outbreak area is the remainder of the facility.
Pandemic Relief Staff	Staff specifically hired to help in times of pandemics, endemics or outbreaks of diseases of public health significance. They have a work rotation designed to cover a portion of the relief coverage needs. (Such as deployed workers, pandemic support workers and agency staff)
Personal Protective Equipment	Includes items worn by healthcare workers to provide a barrier to help prevent potential exposure to infectious disease. These items include: medical masks/N95 masks, eye protection/face shields, gloves, gowns, may also include shoe covers.
Semi-critical items	Devices that come in contact with non-intact skin or mucous membranes but ordinarily do not penetrate them. Reprocessing semi-critical items involves meticulous cleaning followed preferably by high-level disinfection.
Sterilization	Refers to the destruction of all forms of microbial life including bacteria, viruses, spores, and fungi. Items must be cleaned thoroughly before effective sterilization can take place.

Introduction

Long term care homes in Ontario are required to have emergency plans in place that comply with the new Fixing Long Term Care Act, 2021 and Ontario Regulation 246/22. This plan must include measures for preparing and managing emergencies such as pandemics.

The Pioneer Ridge pandemic response plan was enhanced in response to the World Health Organization (WHO) declaring a worldwide SARS-COV-2 pandemic, also known as Covid-19, in March 2020.

Since the pandemic was declared, the virus of concern has spread to over 70 countries, covering 6 continents. During the development of this plan, the SARS-COV-2 pandemic is ongoing and ever-changing across the globe.

As a result of this global public health emergency, there were many lessons learned by healthcare organizations across the province of Ontario; particularly in Long Term Care facilities.

While we had existing plans to manage various types of outbreaks, including a pandemic, the fact that we all experienced a real-time pandemic helped us identify areas for improvement. Further improvements to our emergency preparedness plan were developed to prepare the home, employees, families, residents, visitors and volunteers in the event of future emergencies of significant public health concern, such as outbreaks, pandemics, endemics.

The goal of this plan is to provide guidance on how these emergencies will be addressed and what immediate measures will be implemented to reduce the risk and ultimately protect the safety of the vulnerable population we serve and our employees.

During any public health emergency with the potential to affect the health and well-being of residents living in the home, we must consider the resident's individual rights and personal beliefs. The home will refer to the Resident Bill of Rights as well as the framework for ethical dilemmas for issues that may arise.

Pioneer Ridge aims to manage public health emergencies internally, with existing resources as to avoid putting additional pressures on the local health system. Internal management would include utilizing resources available to us through the Corporation of the City of Thunder Bay. We would utilize community resources made available to us in order to manage a public health emergency such as the Thunder Bay District Health Unit, IPAC hub, Public Health Ontario partners as well as the local Ontario Health group.

Pioneer Ridge aims to work closely with its worker's unions, including the joint health and safety committee (see definition) as it continues to provide protection of healthcare workers during times of increased risk of workplace related exposures and illnesses.

As we continue to learn from the current pandemic, and ongoing changes in public health recommendations, as well as guidance documents for Ontario Long Term Care home, this emergency plan may require further revisions and updates.

Situations and Assumptions

This emergency preparedness plan is in place to guide Pioneer Ridge managers and employees in the event of a global, international, regional, or local emergency of public health significance, such as outbreaks, pandemics, endemics and/or other diseases of public health concern.

The following outlines potential risks, assumptions and emergency phases that apply to this emergency preparedness plan.

Pioneer Ridge is at risk for the following:

- Healthcare facilities are at risk of pathogens entering their facilities in various ways, resulting in infection, and spread causing outbreaks.
- Individuals living in LTC are at an increased risk of poor outcomes.
- Congregate setting, shared rooms, facilities, and dining spaces increase risk.
- Residents of this facility require special emergency considerations in planning for disasters or emergencies and in ensuring safety.

Assumptions

- The possibility exists that a public health emergency may occur at any time as evidenced by the global SARS-COV-2, also known as Covid-19, pandemic (2020)
- In the event an emergency exceeds the facility's capability, external services and resources may be required.
- Local, provincial and federal agencies may provide assistance, when necessary, but they may not be able to respond immediately. The home needs to be prepared to manage an emergency with existing resources and care for the needs of residents, employees, visitors safely.
- The home will aim to maintain standards of care and comply with LTC specific legislation.
- The home will aim to respect the rights of individuals to maintain connections and decision-making while balancing the safety risks.
- The home will provide resources and access to supplies to keep employees safe in the workplace.
- The home will manage emergencies internally to lessen the burden on the healthcare system.

Emergency Response Team: Designated Coordinators, Roles & Responsibilities

The home's IPAC emergency response team includes the following individuals. Each role has responsibilities under this plan which are outlined in the following pages of this document.

- IPAC Coordinator
- Administrator
- Director of Nursing
- Clinical Nurse Managers
- Best Practice Clinician
- Nutrition & Food Services (NFS) Manager
- Environmental Services Supervisor
- Therapeutic Recreation Supervisor
- Medical Director
- Local Medical officer of Health (or designate)
- Registered Nurse(s)
- TDQI Lead
- Administrative Assistant
- Nurse led outreach NP (adhoc)
- JHSC representation

Roles & Responsibilities

IPAC Coordinator

- General oversight of IPAC practices in the home.
- Provides communication/updates front line staff.
- Manages the home's IPAC auditing practices.
- Completes mandatory self-assessment/auditing during IPAC emergencies/outbreaks.
- Resource for IPAC measures.
- Organizes/Chairs IPAC management team meetings.
- Manages the oversight of IPAC outbreaks/emergency in collaboration with the Director of Nursing.
- Communicates with the public health nurse during outbreaks.

Administrator

- Communications officer.
- Link between Pioneer Ridge & the Corporation, local health partners, emergency response partners, Ontario Health, Ministry of Health LTC.
- Oversees the general operation of the home/use of the emergency response plan.
- Ensures that mandatory reporting requirements are met.
- Directs the management/administration team during IPAC emergencies/outbreaks.
- Follows up with administration department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting.

Administrative Assistant

- Schedules the IPAC management team meetings, sends invites to all members.
- Provides assistance to the Admin. Team with communication with families/visitors.

Director of Nursing

- General oversight of daily care/concerns.
- Monitors nursing department staffing levels/initiates the contingency plan.
- Manages outbreaks/IPAC emergencies with IPAC coordinator (co-lead/alternate).
- Completes mandatory reporting per MOHLTC Fixing Long Term Care Act, Regs.
- Ensures completion of mandatory MOL reporting for the nursing department in collaboration with the Clinical Managers.
- Directs the Clinical Managers/RNs/Centralized Scheduling during IPAC emergencies/outbreaks.
- Follows up with nursing department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting (RN, RCW, Scheduling, RC, RAI-C).
- Works with the Medical Director in the development of medical orders for diagnostic testing to be implemented by nursing (such as specimen collection).
- Works with the pharmacy provider's dedicated pharmacist and medical director in the development, implementation and sharing of standardized treatment plans/directives to be used in the home as it relates to new treatments and immunizations per public health recommendations.

Clinical Nurse Managers

- Assist in the management of staffing for the nursing department/contingency plan.
- Oversees daily operations of designated home areas.
- Addresses clinical concerns.
- Monitors compliance with IPAC measures and contributes to auditing nursing practices.
- Provides guidance to nursing department employees/residents/visitors as it relates to IPAC measures, questions, concerns in collaboration with the DON and IPAC coordinator.
- Follows up with nursing department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting.
- Works in collaboration with the DON to develop and implement new nursing practices related to diseases of concern such as immunization and treatment plans, including diagnostics (specimen collection).

NFS Manager

- Manages procurement of emergency supplies, including PPE in collaboration with the home's storekeeper.
- Works with the corporation's procurement/general stores departments.

- Monitors food/fluid supply for the home, ensures emergency supplies available in the event of supply chain issues.
- Monitors NFS staff's compliance with IPAC procedures as they relate to safe handling of foods.
- Manages setting up of dining rooms for outbreaks/IPAC emergencies in resident home areas/dedicated relocation space/implementation of 2nd dining room as needed.

- Ensures that adequate safe water/fluid alternatives such as popsicles, jello, pudding and dietary supplements are available.
- Follows up with NFS department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting.

Storekeeper

- Manages stock of supplies/PPE in collaboration with the NFS manager.
- Ensures PPE caddies are ready to go for all IPAC needs.
- Prepares the outbreak supply cart/replenishes daily.
- Responds to and addresses supply needs/demands during weekday hours.
- Ensures medical supply are available for IPAC needs, including IV/SC fluids and supplies, needles/syringes.

Financial Services Supervisor

- Works with administrator as it relates to Pioneer Ridge finances and contingency funds.
- Seeks emergency funding opportunities in collaboration with the home's administrator.
- Allocation of funds.
- Allocates staffing resources as needed in the emergency, such as assistance with communication to families, occupancy reports, etc.
- Follows up with financial services department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting.

Environmental Services Supervisor

- Monitors staffing resources during emergencies, implements contingency plans.
- Ensures all housekeeping staff are updated with training related to environmental cleaning practices.
- Audits cleaning/disinfecting practices during the emergency.
- Allocates resources where they are needed.
- Directs maintenance with emergency tasks such as setting up space for relocation of residents/movement of residents.
- Monitors safe handling of soiled linen, laundering services.
- Follows up with environmental services department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting.

Therapeutic Recreation Supervisor

- Gathers therapeutic recreationists at the beginning of the IPAC ERP to review planned. calendar activities, works with them to determine appropriate shifts in activity plans.
- Informs volunteers about activated ERP.

- Ensures that residents are receiving socialization through 1:1/cohort activities.
- Works with TR staff to facilitate requests for virtual visits between residents and families/friends.
- Follows up with therapeutic recreation department employees affected by workplace illnesses related to outbreaks and other IPAC related workplace injuries – completes required reporting.

Best Practice Clinician

- Assists in the delivery of IPAC education and training activities for the nursing department.
- Works with the IPAC coordinator to ensure evidence-based practices are followed.
- Assists the RNs in outbreak management tasks such as proper completion of line listing, scheduling of testing activities and immunizations.
- Assists front line staff with meeting care needs as required.
- Works with the nursing managers and storekeeper to ensure that appropriate medical supplies such as iv/sc hydration, immunization supplies, testing supplies are available to meet the increased needs.
- Acts as a clinical resource for the nursing team.
- Assists in the provision of food/fluids to residents as required.

RAI/RCW

- Assist nursing teams to meet the legislative requirements for completion of assessments and other tasks based on limited resources/increased demands.
- Assists with provision of food/fluids to residents as required.
- Assists in providing additional assistive devices for the relocation of residents and assists in the physical relocation.
- Assists the nursing management in meeting the increased demands in care as needed.
- Completes a personal risk assessment prior to each resident contact.

Resident Counsellor

- Monitors and reports on bed management.
- Provides supports to residents and their families during difficult/challenging times.
- Works with the management team to address ethical dilemmas as they arise.
- Manages admissions to the home per outbreak/public health emergency directives and guidelines.
- Works with the local Ontario health teams to manage demands for beds in collaboration with the Director of Nursing and/or Administrator.
- Assists in providing employees with support, resources, debriefing after difficult experiences related to the activation of the emergency measures/resident outcomes/deaths.
- Assists in providing employees with support, resources, debriefing in collaboration with the administrative team if an employee has poor outcomes as a result of the public health emergency.

Training, Development and Quality Improvement Lead

- Assists in the delivery and planning of education and training in the home.
- Assists in tracking quality improvement needs and actions in the home as a result of the activation of emergency response measures.
- Assists in writing communication plans, policies, procedures, and protocols as per administration/management teams as needed.
- Assists in the delivery and communication of new policies, procedures, and protocols as tracking of education.
- Verifies Mask Fit tracking, ensure that all employees working directly with residents are up to date with mask fit testing – offers/arranges testing as required.
- Facilitates scheduling of orientation for all new hires, displaced employees, and agency staff to meet the increase in demands for staffing resources.

Behavioural Support Lead

- Offers support and guidance as it relates to the management of residents with cognitive impairments, need to wander, behaviours, etc. during emergencies.
- Assists nursing teams in developing plans of care for individuals that meet their needs
- Provides education to staff regarding safe wandering plans that comply with infection prevention and control measures.
- Assists in the provision of food and fluids.
- Assists in any relocation plans that relate to residents who are at higher risk of wandering, confusion, poor outcomes due to cognitive based diseases/impairments.
- Provides support to families of residents with cognitive based diseases/impairments as it relates to additional resident/family supports in emergencies requiring isolation.
- Works with the therapeutic recreation team to develop plans for meaningful activities.

Registered Nurses

- Identify and alert IPAC lead and nursing management of any resident symptoms.
- Daily surveillance and documentation of signs/symptoms.
- Initiates additional precautions/isolation immediately when signs/symptoms appear.
- Applies appropriate signage for type of precautions/PPE/outbreak signs – or delegates and ensures this task is complete.
- Documents resident infections on the home area tracking form.
- Participates in outbreak/IPAC meetings, provides status updates.
- Monitors compliance with hand hygiene and PPE usage – completes audits.
- Notification of resident/POA/SDM.
- Ensures completion of testing activities when symptoms arise/outbreak testing – completes documentation and follow up on results.
- Communicates medical needs of residents to the physician, NP, medical director as needed.
- Ensures and assists in the provision of food and fluids, monitors changes in intake.
- Reports needs for additional assistance in the provision of food and fluids to managers as needed.
- Initiates provision of additional fluids as required – obtains alternate fluid options as required.
- Ensures the provision of medications.
- Informs the Dietician of resident changes for follow up assessment.
- Initiates line listing when residents present with symptoms – monitoring line list/outbreak line list/staffing line lists. Faxes these to the health unit daily at 8 am – provides copies to the DON and IPAC coordinator.
- Provides on the spot training as required.
- Assists in the movement of staff to meet care requirements while minimizing mixing of cohorts.
- Screens employee sick calls for potential outbreak/disease of public health concern symptoms, advises them on requirements. Contacts centralized scheduling for staff replacement or initiates replacement/staff call outs after hours.
- Reports calls related to work related illnesses to the DON, employee's manager.
- Reports workload issues/meeting daily care needs to the clinical managers to determine plan of action.
- Completes a personal risk assessment prior to each resident contact.
- Ensures that the home area in an outbreak has ample PPE supply to meet demands/coordinates communication of needs with RPN to the storekeeper.
- Ensure that the outbreak supply cart is placed outside each home area door by 7 am weekdays during outbreaks so that the storekeeper is alerted that supplies are required.

Registered Practical Nurses

- Ensures the provision of medication.
- Ensures and assists in the provision of food and fluids, monitors and reports changes in intake to the RN and dietician.
- Assists in the provision of testing, immunizations as they relate to the public health emergency.
- Monitors compliance with hand hygiene and PPE usage – completes audits.
- Monitor all residents in the home area for signs and symptoms, documents on these each shift and reports changes to the RN.
- Assists in communication with families regarding IPAC measures, provides support and on the spot training on the proper use of PPE for essential caregivers/visitors.
- Completes a personal risk assessment prior to each resident contact.
- Reports personal symptoms to manager immediately.
- Ensures that PPE stock is replenished on care carts, med room/carts and PPE caddies, delegates stocking of PPE to PSW in resident care areas.
- Works with the RN to ensure that the home area has ample PPE supply to meet demands/requests supplies from the storekeeper weekdays through storekeeper cell number.
- Places the outbreak PPE cart outside of home area doors by 7 am each morning for the storekeeper to replenish PPE stock.

Personal Support Workers

- Ensures the provision of food and fluids – report changes to the RPN.
- Ensures the provision of care – reports issues with workload to the RPN/RN.
- Follows IPAC measures – hand hygiene, PPE, proper donning/doffing with care.
- Identifies any signs/symptoms and/or resident changes – leave resident in room for new/unusual signs and reports these to the RPN on duty immediately for assessment.
- Completes a personal risk assessment prior to each resident contact.
- Reports personal symptoms to manager immediately.
- Stocks caddies and applicable care carts with PPE supplies before the end of each shift.

Home Support Staff

- Assist in the provision of food and fluids – report changes to the RPN.
- Assist in the provision of care – reports issues with workload to the RPN/RN.
- Assist in the implementation of isolation or IPAC measures for residents as required.
- Follows IPAC measures – hand hygiene, PPE, proper donning/doffing with care.
- Completes a personal risk assessment prior to each resident contact.
- Reports personal symptoms to manager immediately.
- Stocking caddies and care carts with PPE supplies. Report any shortages to the RPN/RN.

Centralized Scheduling

- Works to ensure staffing levels are met.
- Reports staffing needs to appropriate manager when unable to fill shifts.
- Works with managers to implement staffing contingency plans.
- Reports staffing shortages to the managers and RNs daily.
- Assists in scheduling new employee/agency staff orientation and training.
- Reports need for additional scheduling support to DON immediately.

Therapeutic Recreation Staff

- Promotes socialization and activities for residents in accordance with IPAC measures.
- Facilitation of visitations and connections between residents, families, and friends with the use of technology, video calls.
- Facilitates the inclusion of residents in resident council meetings virtually with the use of technology.
- Assists in the provision of food and fluids when needs are identified by nursing teams.
- Provides support to residents and families as it relates to psychosocial, emotional needs.

Housekeepers

- Provide enhanced cleaning and disinfection of resident care areas, including high touch surfaces twice daily.
- Follow IPAC protocols for environmental cleaning.
- Report needs for additional training to supervisor.
- Communicates with nursing teams on home areas, to determine highest needs and any discharge/end of isolation cleaning required.
- Follows appropriate use of PPE/additional precautions.
- Reports supply needs to supervisor.
- Reports issues with meeting work demands/additional supports to supervisor.

Joint Health and Safety Committee

- Provide representation from the committee on emergency response team meetings as needed, including outbreak management team meetings. Fair representation should include one management/non union and one worker/union representative.
- Represent the interest of workers from various unions working at Pioneer Ridge and Jasper Place Supportive Housing.
- Provide input into matters related to the protection of workers from workplace related illnesses.
- Provide input into selection of personal protective equipment and other measures implemented to reduce the risk to workers.
- Promote and support measures implemented by the home to reduce the risk to residents, families, visitors and employees.

Organizational Goals

- To protect residents and staff by minimizing the risk of serious illness and death
- To protect residents while considering their individual rights
- To minimize the psychological, social, and economic impact
- To minimize disruption in the daily operations of the home
- To minimize disruptions in the resident's routines and activities of daily living
- To maintain adequate human resources to meet care needs
- To minimize disruptions in visitations and essential care
- To allow for ongoing support and socialization while reducing risk
- To maintain community partnerships
- To identify and discuss ethical considerations related to public health emergencies
- To continue to provide essential medical care services within the home
- To have an adequate supply of personal protective equipment and cleaning/disinfecting supplies on hand to manage initial days of a public health emergency
- To have a screening, testing, immunization plan in the event they are necessary
- To clearly identify roles and responsibilities as it relates to infection prevention and control policies, procedures and protocols
- To utilize corporate resources, where able.
- To have a clear communication plan
- To have supports in place to assist employees in managing their needs during emergency situations

Emergency Response Plan: Activation Stages

This emergency response plan is meant to be used in situations where the risk to public health in Ontario is heightened due to illnesses and diseases of concern; that are causing outbreaks with impact on the healthcare system of the province or locally, pandemics or endemics.

Phases under this Emergency Plan

- Pre-Activation

  The phase where the home takes out this plan. It is the planning and monitoring phase of the plan in preparedness for a declared pandemic. Measures are implemented with a goal of reducing the risk to the home and those who live and work here.

- Activation

  The phase where there is local community spread and there's a potential for outbreaks in the home. This phase also consists of steps to follow when there is potential, suspected or actual cases in the home.

- De-activation

  The phase where we have established measures and knowledge about a disease of significance. There are established procedures to manage cases and outbreaks, there may be treatments and vaccines available. Public health may have established the disease as manageable under known guidance documents.

- Debriefing
  The phase where the home's outbreak management team prepares an overall review of the infection control emergency and its outcomes, as well as improvements made.

- Recovery
  The phase where the home, residents, employees, and others may need to rebuild capacity and overall comfort with moving forward. The need for additional supports may be required during this transitional phase.

- Evaluation of Emergency Response Plan
  The phase where the plan's effectiveness is evaluated after use. This plan is also included in the annual review of the home's IPAC program.

Pre-Activation

The IPAC Coordinator regularly monitors local, provincial, international, and global trends as it relates to illnesses of public health significance by reviewing updates shared by local and provincial health authorities.

All public health related IPAC updates are shared with the home's Quality Management team members; as well as all home staff when trends are identified as having the potential for local risk.

Local risk would be considered when outbreaks of public health significance are occurring in the province of Ontario, neighbouring provinces and/or states where risk of transmission through travel exists.

Individual risks would be considered as well, when residents, families, visitors, employees are known to have travelled to a location/country where outbreaks of public health concern are in existence. This would not always be possible due to privacy considerations; but must be considered when risk is identified and reported.

When diseases of public health significance are communicated by the local public health authorities as of concern locally and/or reportable, the IPAC coordinator will gather guidance documents made available by the ministry of health LTC, Public Health Ontario and the TBDHU.

All applicable resources will be used to prepare a temporary policy and procedure to guide the management of the disease of public health significance in the event local cases are identified.

This temporary policy and procedure will be reviewed by the IPAC management team for approval and implemented in the home as a working document, which will continue to be updated as new direction/guidelines are received.

These initial policies and procedures may be prepared in consultation with local health authorities, employees, residents and families or others as applicable.

Other pre-activation measures may include the following**:**

- Completing a home-based, resident focused, risk assessment and re-evaluating the risk bi-weekly, at a minimum.
- Developing and implementing tools when the risk is identified.
- Implement enhanced monitoring of residents presenting with signs and symptoms.
- Initiating more frequent IPAC management team meetings to encourage ongoing discussions and provide status updates.
- Ongoing communication with the local public health unit/IPAC hub.
- Keeping updated on local and provincial guidelines.
- Regular monitoring and evaluation of staffing levels.
- Regular monitoring for supply chain issues.
- Review the temporary relocation supply list to determine if enough supplies are on hand in the event a relocation was required.

Activation

When a disease of public health significance is resulting in cases, outbreaks, or declared as a pandemic affecting the region, the IPAC management team will meet to discuss the activation of this plan.

This decision will be made by considering the following:

- Number of people affected in the Thunder Bay District
- Current impact on the local health system and emergency services
- Risks to the resident demographic living in the home; including morbidity and mortality risk
- Risks to the employees of the home
- Potential for disruption in care due to staffing shortages
- Potential for supply management issues
- Overall risk to the operations of the home due to risk of exposures related to the movement of residents, employees, visitors and other service providers between the community and Pioneer Ridge
- Public attitudes and behaviours with a potential of increasing risk in the community
- Feedback/guidance from local, provincial, federal health authorities & governing bodies

The ultimate decision will be made by the home's Administrator (or delegate)

The plan for communication will be initiated immediately by the IPAC management team upon declaring this emergency procedure as active. See Communication Plan (Appendix A).

Phase 1 - Initial Measures:

- Passive screening of all who enter the home for signs and symptoms of illness.
- RNs and nurse managers will review education/protocols regarding outbreak management. procedures, including line listing, any testing and immunization protocols as required.
- Enhanced surveillance and monitoring for signs and symptoms of illness in residents & staff.
- Implementing measures immediately to reduce the risk until a diagnosis is confirmed (isolation and additional precautions).
- IPAC training will be made available for all staff and essential caregivers.
- The Storekeeper will assess the emergency supplies; ensure that at minimum of 3-week supply is available in house and order additional supplies as required.
- The Food Services Manager will assess food supply, ensuring access to emergency stock in the event of supply chain issues. Determine the need to procure local food supplies.
- The Environmental Services Supervisor will assess the current supply of cleaning and disinfection products to ensure they are appropriate based on the identified agent of concern.
- The Administrator, DON and IPAC coordinator will work on reviewing regular updates from the Ministry of Health LTC, Public health Ontario and other health authorities. These updates will be used to guide the home as we work to implement additional measures specific to the disease that triggered activation of this plan.
- The home's Administrator will communicate regularly with the COTB administration team; including the corporate HR department about the current status and potential supports needed.

- Collaborative plans and resources will be initiated with COTB Directors as required, such as emergency services, human resources, CTB information & technology and procurement services.
- The home's Administrator will reach out to local health partners to initiate regular meetings regarding the local status during the emergency and will update internal stakeholders on the external limitations on resources as applicable, such as the TBRHSC emergency department/ICU, Ontario health partners, local LTC homes, TBDHU, EMS.
- Each department will evaluate their staffing levels and emergency staffing plans to ensure they will meet demands in the event of an internal staffing crisis. Staffing contingency plans will be initiated when staffing demands increase.
- Staffing updates will be discussed at weekly IPAC management meetings. Outsourcing of services will be considered as needed either by obtaining employee supports through the Corporation of the CTB, local contracts and staffing agencies as required.
- The temporary resident relocation site will be set up by the maintenance department in the auditorium with basic supplies and dividers in the event prompt movement is required. See Appendix S.
- A pandemic outbreak cart will be prepared by the storekeeper for immediate implementation of additional precautions where needed, in addition to additional PPE door caddies.
- Food services will be limited to home areas; with food service staff remaining on the home area for the duration of their shift with deliveries from the kitchen as needed to limit movement between areas/departments.
- Pharmacy medication deliveries will be limited to the back entrance, with the RN assigned to meet the driver at this door to collect resident medication.
- Laboratory services will continue with additional precautions based on lab service policies and procedures. If lab services are limited for regular investigations, the nursing management team will work with the RNs and physician/NP to determine what laboratory tests are essential.
- PT/PTA services will continue; but services will be limited to the resident rooms where able. Any resident who requires use of equipment in the therapy room will be provided access on an individual basis, if asymptomatic, with additional precautions in place, including cleaning/disinfection of equipment and surfaces after use.
- The home will aim to respect the resident's rights to receive visitors and socialization while balancing risks. In the initial phase of the plan's activation, services may be limited to 1:1 therapeutic recreation to promote socialization based on risk assessment; including the facilitation of video calls between residents and loved ones where needed.
- Hairdressing services will continue but in limited conditions. See Appendix E.
- The home's Administrator will create a plan to allow safe movement between Pioneer Ridge and Jasper Place individuals (spouses, siblings) through screening methods in collaboration with the Jasper Place program manager.
- Pioneer Ridge will cease access to the home from the attached Childcare Centre Grace Remus. Intergenerational programming will be put on hold. Food services will continue to be provided, with a food cart delivered to the centre doors.
- All home meetings and care conferences will be moved to virtual or telephone meetings; until deemed safe.
- Restorative Care services will continue to be offered with services limited to certain cohorts per day to reduce movement within the home.

- The Director of Nursing will work with the Medical Director, Nurse Practitioner, and other home's physicians to develop medical directives as applicable.
- The IPAC management team will work together with the local pharmacy provider to develop treatment plans/protocols based on public health recommendations as they arise.
- The DON will ensure there is sufficient supply of medical equipment, devices, and supplies in the home in the event of an outbreak.
- The IPAC management team will work together with the local public health unit to develop immunization procurement plans and the delivery of immunizations to residents and employees as applicable. The utilization of EMS services may be considered to assist in expediting this process during the initial vaccination phases. See Appendix J.

The above measures will be implemented as the initial phase of the Pioneer Ridge IPAC emergency response plan. Some of these measures may vary based on applicable mandates, directives, and guidelines, as well as the type of communicable disease posing risk.

Phase 2 – Potential or Actual Case in the Home

All phase 1 measures will remain in place in this phase, unless otherwise directed by public health guidance and/or ministry of health mandates and directives.

Potential/Suspected Case

1. If a resident has been exposed to, has symptoms or is known to be positive for a disease of public health concern, isolation and additional precautions will be implemented immediately by home area staff.
2. Precaution signage and a PPE caddy will be placed on the affected resident's room door, with dedicated commode, medical equipment as necessary, soiled linen and garbage receptacles.
3. The RN on duty will complete an assessment of the resident and report this assessment and suspicions to the resident's physician or NP, as well as the DON/IPAC coordinator.
4. The resident and/or POA will be informed of measures and consent will be obtained for lab specimen collection as required. The RN or delegate will obtain the required specimen and send to the public health lab.
5. A caution sign will be placed on the closed home area door indicating to staff and visitors that we are monitoring for signs of illness. Enhanced monitoring for signs and symptoms in all residents & staff will be completed by staff each shift.

Confirmed Case

1. The Director of Nursing (or delegate) and IPAC coordinator will obtain the case details from the RN and contact the local public health unit to complete a mandatory report once a case is confirmed in the home.
2. Initial guidance will be obtained from the public health unit and followed by the home.
3. The IPAC coordinator will initiate an outbreak management team meeting which will be followed by regular follow up meetings during the time where active cases are identified in the home. The delegate for the local medical officer of health will be invited to attend these meetings.
4. The IPAC coordinator will send communication to all home employees, including the medical director and nurse practitioner and any other practicing physicians regarding case status and updates.
5. The RN will notify the resident/family of the positive result, measures taken and next steps.

6. Home area staff will notify all residents and/or their SDM if their unit has been declared an outbreak.
7. The IPAC coordinator will prepare communication to send to all SDM/ECGs with outbreak notification and regular update statuses. The administrative assistant will assist with the delivery of this communication by email or post.
8. Contact tracing will be initiated, first identifying higher risk exposures such as roommates, tablemates and implementing isolation/additional precautions for these. Consent for testing will be obtained if required.
9. Implementation of unit-wide mandatory masking if it is related to a respiratory illness (if not already initiated in phase 1).
10. Contact tracing will then focus on any visitors and employees. Those identified will be asked to monitor for symptoms and may be subject to self-isolation and testing as required based on public health guidance.
11. Residents living in semi-private accommodations may remain in their room in isolation. The wardrobe between resident spaces with the closed curtains provide a sufficient barrier for most communicable illnesses. The use of the shared washroom will be limited, with one resident being provided with a dedicated commode as needed. If other measures are required based on public health guidance, the relocation of residents may need to be considered.
12. Movement of residents from the affected home area will be limited to emergencies.
13. Employees working in this home area will be assigned to work within defined cohorts, and those working with the affected resident(s) and close contacts will be restricted from working with well residents. Timelines between working in different cohorts may vary based on the causative agent and identified restrictions. See Appendix P.
14. Employees who develop symptoms while at work will be assessed by the RN, tested if required then sent home for self-isolation. See the procedure on the management of affected employees. See Appendix L.
15. Housekeeping staff will be advised to implement enhanced cleaning and disinfection protocols, minimum twice daily for high touch surfaces. See Section Specific Considerations in Appendix N.
16. Laundry staff will be restricted from delivering clothing to individual rooms on the affected home area; clean linen carts will be delivered outside the home area doors.
17. Meal service will be provided to ill resident(s) via tray service. Disposable items may be used and disposed of prior to removing the tray from the affected resident room.
18. Essential caregivers may be permitted access to the home with guidance on how to use PPE, what PPE to use and proper disposal, and hand hygiene practices. Access to visit may be limited based on public health restrictions/ministry of health mandates. See Appendix U.
19. The air quality will be evaluated by the environmental services supervisor in collaboration with the IPAC management team in the event of respiratory based illnesses. Air purifiers may be placed in affected home areas, shared spaces or resident rooms as deemed appropriate. The use of fans and window air conditioner units will be restricted for respiratory illnesses.
20. In the event a positive case passes away, refer to Appendix N for nursing specific considerations.
21. Refer to Appendix T for further information about the management of covid-19 and other emergency related outbreaks.

Specific guidelines related to additional emergency response measures under this plan can be found under the appendices as outlined in the table of contents.

The emergency response plan for infection prevention and control is a fluid plan, where phase 1 measures remain in place during the entirety of the plan activation; and stage 2 measures are implemented to manage actual cases/outbreaks within the home.

This process will continue to be followed until the time disease specific policies, procedures and protocols are established in the home based on public health authorities and ministry of long-term care acts and regulations, and this emergency plan is de-activated**.**

De-Activation

De-activation of the IPAC emergency response plan will be based on the evolution of the emergency, applicable public health guidance, applicable MOHLTC direction, local risks based on the local medical officer of health recommendations as well as whether existing risks to the operation and management of the home continue such as staffing issues, supply management issues, ongoing cases/outbreaks, etc.

De-activation will be decided collectively by the IPAC management team in consultation with all those affected directly by the plan, such as: residents, home employees, family council, local health partners, the manager of corporate services and LTC.

Once policies, procedures and processes are established in the home for diseases that triggered activation of this plan, and the risk of public health crisis is reduced, the home may consider de-activating the emergency plan and implementing standard IPAC protocols as it relates to outbreak management.

The final determination to de-activate the emergency plan will be done by the home's administrator. The de-activation of the plan will trigger the use of the communication plan, with the addition of a plan to schedule a debriefing meeting with all stakeholders.

Recovery

Recovery from a public health emergency may take some time, as evidenced by the most recent SARS-COV-2 pandemic. Ongoing measures may remain in place, and the home may move between stage 1 and 2 up to the time the disease of public health significance or pandemic risk has decreased, or it has officially been declared an endemic.

The de-activation of this plan may be considered when the IPAC management team feels that the emergency measures are no longer required, and that the home has established adequate policies, procedures and protocols to manage ongoing outbreaks related to the disease.

Outbreak management protocols developed as a result of the emergency will be used to manage ongoing waves of the illness.

Prevention measures will be followed in accordance with the home's IPAC program, including the use of standard and routine infection control practices. The home will implement immunization recommendations for residents and employees based on public health and ministry recommendations and continue providing ongoing education about preventing the spread of microorganisms.

Pioneer Ridge recognizes that the recovery plan will need to include steps to manage hesitancy and fears as the home moves toward resuming normal operations. The reduction of additional

precautions and measures will need to be done in a phased approach, beginning with the measures that pose the least risk.

Strategies to assist in managing hesitancy and fears will include the following: ongoing communication, sharing of information used in the decision-making processes, as well as reassurance that any plans are based on public health guidelines and ministry of health guidance and directives.

Debriefing

Pioneer Ridge recognizes that public health emergencies pose significant concern for the health and safety of employees and their families, residents and their families as well as the general public.

We aim to provide open lines of communication with all employees, residents, families and stakeholders during and after the emergency.

Employee and resident/family supports and resources will be offered during activation of this plan and after the emergency is declared over based on identified need.

The home aims to offer supports to those who may be experiencing distress as a result of the emergency. The corporate health and wellness program and EFAP will be offered to staff. The resident counsellor will support families and residents as required.

The IPAC coordinator will perform regular outbreak debriefing sessions to obtain feedback from residents, visitors and others. These will be used for continuous evaluation and quality improvement.

These debriefing sessions will provide additional opportunities to identify needs for additional supports on a regular basis. The outbreak debriefing tool will be used to document these sessions.

An official post-emergency debriefing session will be offered to all residents, families, staff, volunteers and students after the activation of this response plan. The debriefing session will be led by the home's IPAC management team who will provide a general review of the emergency, outcomes and lessons learned.

This debriefing session will include a general summary of the emergency and plan towards resuming normal operations.

Evaluation

Informal evaluation of the plan's effectiveness will be done regularly by the IPAC management team while the plan is active and in use. Measures taken to address gaps during the use of this plan will be documented by individuals on the team and discussed in IPAC management meetings.

Any gaps identified during the active phase of this plan will be documented with any improvement measures identified and implemented; in order to utilize lessons learned to enhance this plan.

All gathered input will be documented and applied to an IPAC quality improvement plan which will be utilized to complete a full review and evaluation of the plan, with any necessary updates made to the plan within 30 days of the emergency being declared over.

The IPAC emergency preparedness plan will be tested by the home annually, with a written record of the test and resulting changes kept by the home. The plan will be reviewed and revised as required on an annual basis.

APPENDICES

Appendix A: Communication Plan

Upon activation of this emergency response plan the communication plan below will be initiated by the IPAC Management Team.

The administrator acts as the communication officer. They will distribute the following communication tasks to each person as indicated in the checklist below and follow up on everyone's progress.

Any tasks related to this communication plan; including media communications will be done by the Administrator or DON in their absence.

Administrator
- City of Thunder Bay Manager/DMT
- Director CSLTC
- City Council
- Local Health Partners
- Unions (Unifor/ONA)
- Joint Health & Safety Committee

Financial Services Supervisor
- Union (SIEU)
- Human Resources Manager

IPAC Coordinator & Nurse Managers
- Nursing department staff/Home Areas
- Public Health Unit
- IPAC Hub Partners
- Any visitors in the home

Director of Nursing
- Laboratory Service Provider
- Physio Service Provider
- Pharmacy Provider
- Centralized Scheduling

Therapeutic Recreation Supervisor
- TR staff
- Resident Council
- Family and Friends Council
- Volunteers
- Students (high school co-op)

Administrative Assistant/Business Office Clerk
- Resident families and friends
- Jasper Place program Manager
- Grace Remus Manager

Training, Development and Quality Improvement Lead
- Manager of Information & Technology Services
- Instructors/program managers for College/University Students in the home\

NFS Manager/ESS
- Departmental staff
- Contractors/Service Providers/Delivery Services

Others added at time of activation:

The IPAC lead will share public health and MLTC updates with the home's staff as required.

Any changes in policies, procedures and processes will be communicated by the management team members.

Communication to families should include expectations such as how often updates will be provided and method i.e. weekly email updates to POA/SDM and ECGs.

RNs will notify the resident/POA/SDM if they are a close contact/positive case and when an outbreak is declared on the home area.

The following script may be used during the initial emergency communication notice:

"Pioneer Ridge has activated their emergency response plan due to the risk of illness that may affect the residents living in the home. The home will be limiting visits to essential caregivers and employees at this time. All deliveries must be made to the back of the building, with a call to the person who is to collect the items. All employees and essential caregivers will be screened upon entry; anyone with symptoms of illness are asked to refrain from coming in. Updates will be provided as required."

Appendix B: Diagnostics: Identifying the Cause

During the onset and management public health emergencies related to pandemics, endemics and diseases of public health significance, the home will need to quickly determine the process for collecting specimens if suspected cases and close contacts to cases are identified.

The goal of the home is to act promptly to identify the causative agent of the illness.

The following items are to be considered when determining steps during an emergency:

- Determine type of illness. Is it gastrointestinal or respiratory?
- Verify the current public health guidance related to specimen collection related to suspected illness.
- Verify the stock of supplies and dates of expiration prior to collecting specimens.
- Consult with the public health infectious disease nurse designated to the home to confirm the outbreak number, number of specimens required and request testing kits if needed.
- There is usually a minimum of 4 specimens required by the public health lab to identify causative agent in an outbreak.
- Ideally, specimens will be obtained from the first cases and those who present with most symptoms.
- All specimens collected due to suspected or confirmed outbreaks of illnesses of public health significance are sent to the local public health lab.
- The Ontario Public Health Laboratory requisition form must be filled and sent with each specimen, including all resident and/or employee demographics as well as the outbreak number.
- Transportation should be made to the lab by an approved transportation service with the lab bag identifying hazardous specimen and outbreak number on a coloured sheet to alert lab technicians to prioritize the specimen(s).

  The regular lab service provider could deliver specimens to the public health lab, as long as the scheduled delivery doesn't delay diagnosis and/or treatment.

The public health laboratory website contains information about disease specific requirements as well as printable requisition forms in the event of need during an emergency, following the link below:

https://www.publichealthontario.ca/en/laboratory-services/about-laboratory-services

On-site testing

On-site specimen testing is limited. Some advances in technology or new diseases of public health significance may allow for on-site rapid testing which would be confirmed by specimens sent to the lab such as seen with the covid-19 pandemic.

In the event of new testing kits being introduced in an emergency event, the home will follow the manufacturer's instructions for the use of the testing kit. Training on the use and details regarding the process will be determined based on public health recommendations.

Appendix C: Education and Training

In the event of an IPAC emergency, the home may be receiving new information regularly regarding the disease of concern that has a potential of impacting the residents, employees and visitors.

All staff receive education and training as it relates to infection prevention and control during orientation, and this information is reviewed at least annually or more often based on needs.

During the initial phases of a public health emergency of concern, the home's emergency response team will consider the need for additional education and training required based on any new practices and procedures being introduced.

The home will provide all staff with a general overview regarding infection prevention measures to reduce the general risk of all persons in the home.

A review of infection prevention, control and management measures will be provided to front line staff. The home may consider providing more education and training to those who are in charge of managing outbreaks, such as nursing managers and the RNs.

The sectional supervisors will work with the IPAC coordinator to determine section specific needs as it relates to managing a new disease of concern, and any need to implement new protocols and training.

The home will provide a general overview of IPAC prevention measures to the residents and essential visitors of the home.

The IPAC education document in this plan that was prepared to be used in the event of an emergency when a quick general overview of IPAC measures is needed to be shared with the residents, visitors and employees of the home.

Outside resources may be used to assist with education such as the IPAC hub online or in-person educational series.

The IPAC education review may be found at the following link:

W:\Pandemic\2022 IPAC FILES\2022 IPAC ERP (June 2022)\IPAC Tools included in the ERP\IPAC ERP Education PPT

Appendix D: Ethical Considerations

In a public health emergency, we may find ourselves questioning whether our existing ideas about what is good, right, and just continue to hold true. We may have to make difficult decisions, which may get in the way of usual care. Some decisions may be made to prevent the virus from entering the home but may also result in moral and ethical dilemmas for healthcare workers.

During IPAC emergencies, the home will strive to achieve the greatest good for the greatest number of people which means protecting the majority of residents and staff while limiting the negative impact on all individuals.

The following principles should be considered when staff and managers are thinking about making a decision during these types of events.

Individual Liberty/Protection of the Public from Harm

During a pandemic, it may be necessary to restrict individual liberty to protect the public from harm. When making decisions designed to protect the public from harm, Pioneer Ridge will weigh the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g., isolation).

Pioneer Ridge will ensure that all those involved are aware of the medical and ethical reasons for the measures, the benefits of complying, and the consequences of not complying.

Proportionality

Restrictions on individual liberty and measures to protect the public from harm should not exceed the minimum required to address the actual level of risk or need in the community. Pioneer Ridge will use the least restrictive or coercive measures possible when limiting or restricting liberties or entitlements.

Privacy

Individuals have a right to privacy, including the privacy of their health information. During a pandemic, it may be necessary to override this right to protect the public from serious harm; however, to be consistent with the ethical principle of proportionality, Pioneer Ridge will limit any disclosure to only the information required to meet legitimate public health needs.

Equity

During a pandemic, Pioneer Ridge will strive to preserve as much equity as possible between all residents, exposed to the virus or not, and to establish fair decision-making processes/criteria for treatment and care.

When Pioneer Ridge has to identify who will have priority access to anti-viral treatments, vaccines or other treatment, they will ensure that everyone is aware of the criteria used to make those decisions.

Duty to provide care/reciprocity

Health care workers have an ethical duty to provide care and respond to suffering. During a pandemic, demands for care may overwhelm health care workers and the institution, creating challenges related to resources, professional practice, liability, and workplace safety. Health care

workers may have to weigh their duty to provide care against competing obligations (i.e., to their own health, family and friends).

To support staff in their efforts to continue to provide care to our residents, Pioneer Ridge will strive to ensure the appropriate supports are in place (e.g., resources, supplies, equipment), provide support for staff to fulfill their personal/family responsibilities, take steps to ease the burden on staff and their families, and establish a mechanism to deal with staff concerns and work exemptions.

Trust

Trust is an essential part of the relationship between organizations and their staff, between the public and health care workers, and among organizations within a health system. Pioneer Ridge will take steps to build trust with staff, families and other organizations before the pandemic occurs, to ensure decision-making processes are ethical and transparent.

Solidarity

A widespread pandemic will require solidarity among community, health care institutions, local public health units, and government. Solidarity requires honest, straightforward communication and open collaboration to share information and coordinated health care delivery.

Stewardship

Pioneer Ridge will be entrusted with governance over scarce resources, such as any available and recommended vaccines, anti-viral treatments, equipment and health care workers.

To ensure good stewardship of scarce resources, Pioneer Ridge will consider both the benefit to the public good and equity (i.e., fair distribution of both benefits and burdens).

Respect for Cultural Diversity/Beliefs

Pioneer Ridge will continue to strive to respect cultural values and religious beliefs of all residents and staff throughout the pandemic.

Transparency

Sharing all options considered and reasons for basing our decision-making with anyone who needs to know will help build trust and understanding.

Isolating People with Contagious Illnesses

Placing residents who are affected by a contagious illness in isolation and away from healthy people is a standard infection prevention and control measure used in healthcare to prevent the spread of disease and illness.

While this measure is meant to be temporary, short term, until the resident is no longer considered infectious, it may cause ethical dilemmas between staff working in a care area affected by illness, particularly when the resident will not stay in their rooms.

The risk outbreaks pose in the home is high due to a congregate living, shared spaces and a resident population who is at higher risk of severe outcomes, including death. We know that implementing measures to break the chain of transmission is crucial in preventing the spread of illness during an outbreak. In the case of isolation to a room, the risk of contact with others is greatly reduced.

As a care provider, we must implement measures to physically isolate a resident from having contact with healthy people but must avoid causing social isolation as best we can. There are several ways to maintain some form of social aspect while a resident is physically isolated to a room temporarily, such as the use of technology to interact with loved ones, phone/video calls, as well as therapeutic recreation activities and exercises on a 1:1 basis.

We must provide education to residents and their families regarding the need to implement isolation and reasons why it is important.

What if a resident will not isolate?

If a resident will not isolate, it is important for nursing staff to collectively consider the underlying reason for their refusal to isolate.

Some residents may not be capable of understanding the reason for isolating in their room due to cognitive impairment or dementia.

Some residents may be capable of understanding but may not have the ability to remember and may forget after instructions were provided.

There are times when residents may exhibit increased signs of distress from the inability to comprehend the reasons they are not permitted to get out of their room while they see other residents moving around freely.

The following principles should be considered when developing a care plan for isolation that supports and comforts the resident:

Personhood

Understanding why the resident keeps coming out of their room. Think about what is known about their individual needs. It is important to know this in order to address them.

Engagement

Residents in isolation may have an increased need for interactions with staff. In order to promote the need to stay in their room, staff may consider setting up a schedule for short staff interactions. During these interactions, positive support can be provided, thanking them for their continued isolation and consider setting them up with a different activity.

Supporting Needs

Consider all the resident's needs in the development of this care plan. Provision of food, fluids, medication, pain management, toileting, social activities and personal connections with their families.

Some residents living with dementia may have the need to wander. This must also be considered when care planning. Supporting safe wandering schedules may be necessary. Staff could consider allowing controlled wandering outside the resident's room, under supervision, with the wearing of a mask as tolerated as well as frequent hand hygiene.

Reminders

Some residents may only require frequent reminders due to problems with short term memory. Consider the use of visual tools as reminders such as door signs, door strips, scripts, or audio tools such as recordings or door alarms.

Other considerations

Another consideration in outbreak situations, particularly on Home Area 1 where more residents have a need to wander and are living with some type of cognitive impairment, is to consider creating a zone where infectious residents can isolate in a space/area together separate from healthy residents. A staff member can be assigned to the space to assist in monitoring, providing meaningful activities, food and fluids.

Other decision-making considerations

- Consider all the risks and benefits of each option.
- Start with less restrictive measures prior to moving to more restrictive ones.
- Be clear about the harm you are trying to prevent.
- Consider other harms that may arise from the options and how these will be minimized.
- Situations are constantly changing in outbreaks or pandemics, therefore approaches and actions made may also need changing as the situation evolves.
- Obtain input from those who will be affected by our decision-making.
- Be open about ideas, consult with stakeholders so that any disagreements could be worked out prior to finalizing a decision.
- We are accountable for decisions, actions or inactions. Facing difficult decisions is better than avoidance.

Consider that trust from residents, staff and their families is crucial in order to put our plans into action. Being able to consider other options, re-evaluate our decisions or accept that not all decisions are the best decisions are all important considerations when managing emergencies.

Appendix E: Hair Dressing Services

In the event of an IPAC ERP activation, there may be restrictions and/or limitations put in place to the hair dressing services in the home based on public health or ministry guidance.

The home's emergency response team may consider putting services on hold at any time an outbreak is declared in the home; when there is heightened risk in the community due to illnesses of public health concern as it is considered a non-essential service.

During facility-wide outbreaks, all non-essential services will be put on hold.

When the home determines that hair care services may continue to be provided, measures will be put in place as follows to reduce the risk of spreading communicable illnesses:

- Hair care services will only be provided to individual resident cohorts in non outbreak areas.
- Hair care services will only be provided to Pioneer Ridge residents.
- Jasper place tenant services may be put on hold to reduce non-essential traffic in the home.
- Services will only be permitted if the service providers abide by the home's IPAC measures and any additional measures implemented based on pubic health and ministry guidance.
- Appointments will be limited to 1 well (symptom-free) resident at a time, unless 2 are reasonable based on the causative agent.
- Field-specific infection control practices, including cleaning/disinfection procedures will be followed between each resident.

Service providers and the volunteers may be subject to mandatory vaccination policies.

Service providers and the volunteers may be subject to using PPE when providing services.

Service providers and the volunteers will need to review infection prevention and control practices along with all others at onset of an emergency.

Portering residents to and from the hair salon may pose a risk based on the type of illness of concern. If there is risk of spreading illness between home areas and cohorts, the emergency response team will evaluate the level of risk and determine if additional precautions are warranted.

The home may consider alternatives in the provision of services in collaboration with the service providers, such as allowing services in individual resident rooms, implementing the use of barriers between sinks and chairs, mask use, etc. These alternative measures will be considered prior to closure of the salon, unless ministry mandates its force closure.

Appendix F: IPAC Audits

Auditing IPAC practices is an important step in reducing the risk of spreading microorganisms with a potential of causing severe illnesses in the home.

Auditing processes will continue during the activation of this emergency response plan.

Audits may be completed more frequently in areas affected by communicable illnesses of concern and in outbreaks.

IPAC Audits led by the IPAC coordinator/Nursing Department

The following audits will be completed each day/on various shifts:

- Hand Hygiene Audits
- Personal Protective Equipment Audits

The following audit/self-assessment will be completed on a minimum weekly basis during declared outbreaks:

- Self Assessment Audit Tool for Long Term Care and Retirement Homes

IPAC Audits led by Nutrition and Food Services Department

The following audit will be completed by the department manager/supervisor or dietician twice weekly at a minimum:

- NFS hand washing audit

IPAC Audits led by Environmental Services Department

The following audits will be completed by the department supervisor twice weekly at a minimum:

- Housekeeping Audit
- Glow germ audits on environmental/high touch surfaces

All audits can be found in the Pandemic Folder under Emergency Response Plan by using the following link:

W:\Pandemic\2022 IPAC FILES\2022 IPAC ERP (June 2022)\IPAC Tools included in the ERP\Audits and Checklists

Appendix G: IPAC Resources and Guidance

The following are general resources and guidance for the emergency response team to share with residents, families and visitors during emergencies of public health concern. These resources may also be shared with all home employees as a reminder, in addition with other training as indicated based on need.

Everyone should practice measures to reduce the risk of spreading illnesses when there is a heightened risk to residents in the home. The risk may be higher during a pandemic with ongoing waves causing increased cases in the city and region, and during flu season between early fall and spring.

General Guidance

The following images illustrate infection control practices for all to follow when risk is high to the vulnerable population who live at Pioneer Ridge. Applying several measures has proven to be effective in providing layers of protection.

Physical Distancing

Physical distancing is a layer of protection used when there are respiratory illnesses that cause colds, coughs and sneezing as some particles can reach a good distance. Covid-19 and its variants are known to come out of the respiratory track when infected carriers talk, sing, etc. Because not everyone may display symptoms, this measure is very important for all to practice.

Hand Hygiene

Hand hygiene, or hand washing, is the most important measure known to reduce the risk of spreading microorganisms that cause illness.

All individuals who enter the home must perform hand washing prior to coming into the main doors, going onto the resident home area and going into the resident's room/having contact with a resident.

Hand hygiene is also indicated upon exit from the resident's room, after touching surfaces and prior to leaving the home.

It is important to also perform hand hygiene following the use of the washroom, after coughing/sneezing, handling soiled items, before eating and before/after using gloves.

All staff are trained the 4 moments for hand hygiene for healthcare workers.

Residents, families and visitors are encouraged to perform hand hygiene as indicated above.

Because residents live in the environment, their hands are exposed to many surfaces and microorganisms during their day. It is important for them to practice regular hand washing.

If a resident is unable to perform hand washing on their own, we ask that everyone prompt or assist them when it is indicated.

When washing your hands, you must use soap and water or antibacterial hand rub. All surfaces of the hand and wrists must be covered and gently rubbed for a minimum of 15 seconds.

If using an antibacterial hand rub, you may need to use more than 1 pump to have enough on your hands to cover all surfaces for the 15 seconds of rub time.

Washing with soap and water is always indicated if your hands are visibly soiled or have been in contact with bodily fluids. Antibacterial hand rub or a disposable hand wipe may be used if no running water and soap are readily available.

The following video demonstrates the technique recommended when performing hand washing with soap and water, as well as antibacterial hand rub.

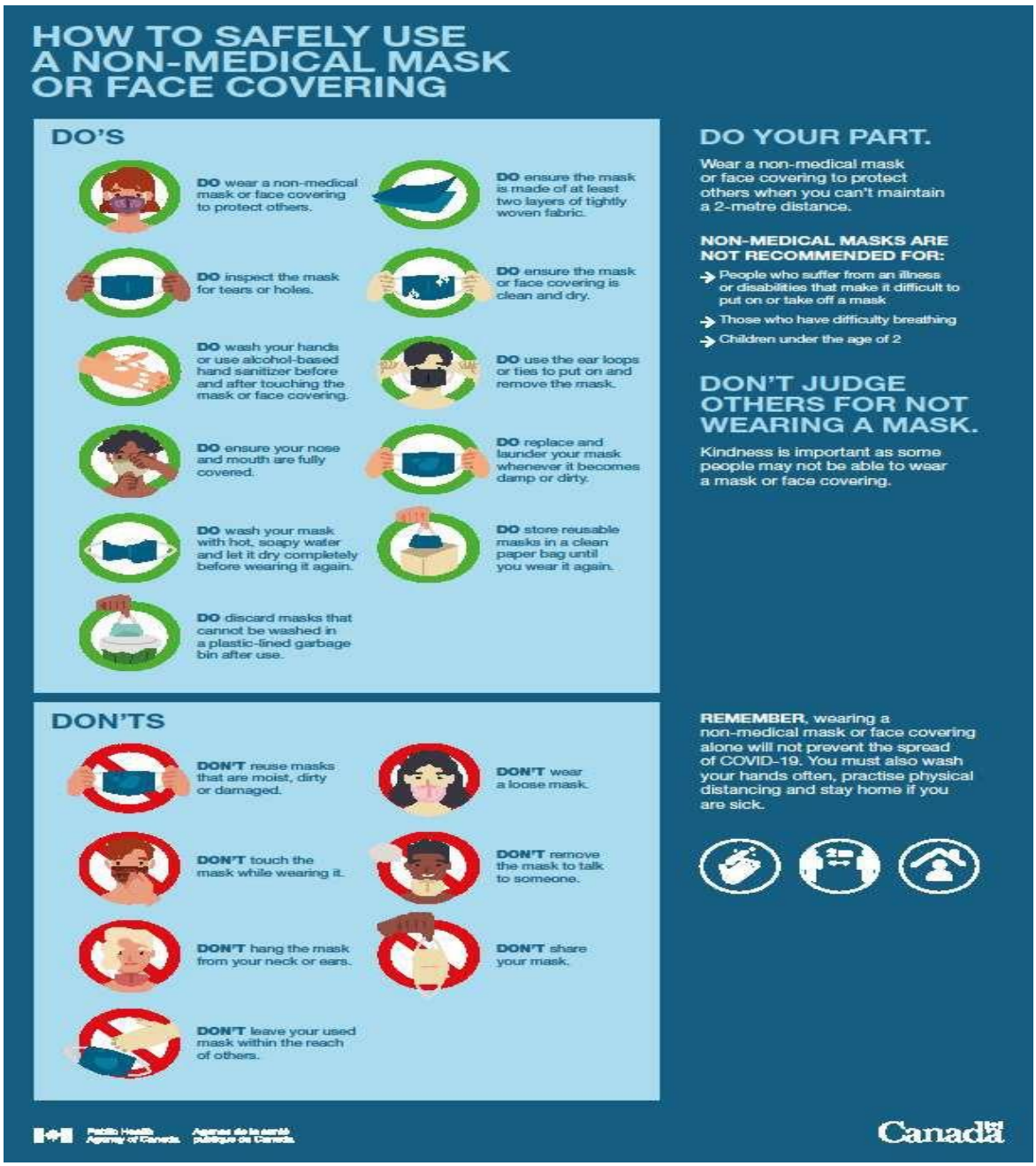
Just Clean Your Hands Videos | Public Health Ontario

The steps are also illustrated on the next page. Remember, timing and technique matters!

Steps for Hand Hygiene

Mask Use

Universal masking may be required during times when respiratory illnesses such as covid-19 are in circulation or new illnesses are presenting themselves in the community. Medical masks will be required to be used at all times when you are in the home. It is important to know how to safely use your mask.



Respiratory Etiquette

Practicing basic respiratory etiquette goes a long way in preventing the spread of illnesses. Examples of respiratory etiquette includes covering coughs and avoiding touching your face.

The following measures are expected to be followed by all individuals who visit and work in the home. Residents are also encouraged to practice respiratory etiquette to the best of their abilities, assistance can be provided by families, visitors and staff. Hand washing is always required after coughing or sneezing.

Additional Precautions and Personal Protective Equipment

Additional precautions may be indicated along with self isolation depending on the type of illness or symptoms a resident is exhibiting to protect others who are in contact with them and their environment.

In some cases, additional precautions are required for reasons that are not related to illness or infection, such as risk of contact with bodily fluids, administering certain medications, potential exposure to chemicals, etc.

Additional precautions include the use of personal protective equipment. Personal protective equipment, also referred to as PPE, may be indicated when within 6 feet/2 metres of a person who has a communicable illness or other indicated risk.

Signage indicating the need for additional precautions will be posted outside the resident's room. This will inform you of what additional measures you should take to protect yourself while you are in the room. Not all measures need to be followed in all cases, as some are only required if assisting with care or handling items. If you are unsure, ask the nursing staff who will be happy to assist you.

It is important to know how to properly use PPE. There is a sequence that is followed by healthcare workers when putting on and removing PPE that minimizes risk of contamination, this is referred to as 'donning and doffing'.

The following link from the local IPAC hub demonstrates the proper use of PPE. The steps to follow are also shown on pages 40-41:

PPE How-To Videos | Thunder Bay District Health Unit (tbdhu.com)

All PPE must be disposed of before exiting a resident's room.

Hand washing with an antibacterial hand rub for 15 seconds on all hand surfaces and wrists in needed before and after removing PPE. The steps to follow are shown on the next pages.

Putting on Personal Protective Equipment

Removing Personal Protective Equipment

Visiting during outbreaks

During outbreaks of communicable diseases, visitors will be limited to essential caregivers.

These measures are needed to reduce the risk of transmitting communicable illnesses between residents, resident care areas, non care areas, as well as your own family, friends and community as a whole.

Essential caregivers are people who provide essential care to residents in the home. These may include family and friends who provide assistance with some daily activities such as feeding at mealtimes.

When there are outbreaks in the home, it is important for all caregivers to take the necessary precautions to protect the residents and themselves from illness, by following to all infection prevention and control measures described above in addition to any public health recommended immunizations.

The home will provide regular updates to residents, families and employees when there may be heightened risk or declared outbreaks in the home.

Our home's Emergency Response Plans are publicly available on our website; including the infection prevention and control (IPAC) emergency preparedness plan outlining all measures and considerations that are put in place during pandemics, endemics and other outbreaks of public health significance.

Follow the link below to view our emergency response plans as well as the most recent version of our visitor and essential caregiver policy:

Pioneer Ridge Long-Term Care and Senior Services - City of Thunder Bay

IPAC Resources

There are a number of resources to consider reviewing when dealing with an emergency related to diseases of public health significance.

The following resources may help guide decision-making related to specific practices/measures to implement during an emergency:

Laws & Regulations

Fixing Long-Term Care Act, 2021 Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1 (ontario.ca)

O. Reg. 246/22 O. Reg. 246/22: GENERAL (ontario.ca)

Resident's Bill of Rights 20220411RBR_English.pdf (ontarc.com)

Emergency Preparedness

https://ltchomes.net/LTCHPORTAL/Content/LTC%20Emergency%20Preparedness%20Manual.pdf

Local Public Health Unit

https://www.tbdhu.com/

IPAC tools

COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes (publichealthontario.ca)

COVID-19: Self-Assessment Audit tool for long-term care homes and retirements homes (publichealthontario.ca)

https://ltchomes.net/LTCHPORTAL/Content/Standard_Operating_Procedure_FINAL_August_24_2022.pdf

https://ltchomes.net/LTCHPORTAL/Content/MLTC_COVID-19_Fall_Preparedness_Checklist_2022_FINAL_August_24_2022.pdf

IPAC Best Practices and Guidance Documents

https://www.publichealthontario.ca/en/Health-Topics/Infection-Prevention-Control/Routine-Practices-Additional-Precautions

Best Practices for Prevention, Surveillance and Infection Control Management of ovel Respiratory Infections in All Health Care Settings (publichealthontario.ca)

Infection Prevention and Control | Public Health Ontario

Infection Prevention and Control for Long-Term Care Homes (publichealthontario.ca)

Environmental Cleaning

Environmental Cleaning | Public Health Ontario

https://www.publichealthontario.ca/en/Health-Topics/Infection-Prevention-Control/Environmental-Cleaning/Environmental-Cleaning-Toolkit

Key Elements of Environmental Cleaning in Healthcare Settings (publichealthontario.ca)

Air Quality

https://www.publichealthontario.ca/-/media/Documents/nCoV/ipac/2020/09/covid-19-hvac-systems-in-buildings.pdf?sc_lang=en

https://www.publichealthontario.ca/-/media/Documents/nCoV/ipac/2021/01/faq-covid-19-portable-air-cleaners.pdf?sc_lang=en

https://www.publichealthontario.ca/-/media/Documents/nCoV/ltcrh/2020/08/covid-19-fans-air-conditioning-ltcrh.pdf?sc_lang=en

Education and Training

COVID-19 IPAC Fundamentals Training | Public Health Ontario

PPE How-To Videos | Thunder Bay District Health Unit (tbdhu.com)

Covid-19 Guidance Documents

https://www.ontario.ca/page/covid-19-guidance-document-long-term-care-homes-ontario

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_LTC_homes_retirement_homes_for_PHUs_guidance.pdf

https://www.ontario.ca/page/ministers-directive-covid-19-response-measures-for-long-term-care-homes

https://www.publichealthontario.ca/-/media/Documents/nCoV/ltcrh/2020/06/covid-19-prevention-management-ltcrh.pdf?sc_lang=en

Cohorting

Cohorting During an Outbreak of COVID-19 in Long-Term Care Homes (publichealthontario.ca)

https://www.publichealthontario.ca/-/media/Documents/C/24/cohorting-respiratory-virus-outbreaks.pdf

IPAC Infographic - Cohorting options in outbreak facilities (publichealthontario.ca)

De-escalation Documents

De-escalation of COVID-19 Outbreak Control Measures in Long-term Care and Retirement Homes (publichealthontario.ca)

Critical PPE/Testing Kit Request Ontario

https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake?a=ppe-intake

Public Health Lab

https://www.publichealthontario.ca/en/laboratory-services/about-laboratory-services

Appendix H: LTC Outbreak Response Supports

During declared outbreaks of diseases of concern, the home will work with the local public health unit's Infectious Diseases Nurse who is the delegate for the Medical Officer of Health for Pioneer Ridge.

The Infectious Diseases Nurse for may be reached by using the contact information below.

Other Public Health resources include the IPAC hub who may complete site visits at the onset of outbreaks and/or provide education and resources.

The Public Health Laboratory completes lab testing on specimens sent. Results are faxed on the office's confidential fax, but these can also be obtained by calling the number below.

General Thunder Bay District Health Unit Information (807) 625-5900
IPAC Hub IPACHub@tbdhu.com
Infectious Diseases Nurse (weekdays) Susan Armstrong 625-8317
On-call ID nurse (after-hours/weekends) 624-1280 (answering service)
Fax Line Lists 625-4822
Public Health Laboratory Results (877)604-4567

Appendix I: Medication Management Plan

The goal of this plan is to maintain the provision of medication to residents in an emergency such as a pandemic, endemic and/or other disease of public health significance.

The home will work with the pharmacy provider to ensure that medication will be made available to residents of the home during times when the supply may be affected.

The home's medical director will collaborate with the pharmacist to make any necessary changes to medication orders as required per current procedures if medications are not available or on back order.

There may be times when necessary medications will be prioritized based on supply and demand, resident specific needs, as well as other emergency factors.

The medication pass times are not anticipated to change unless there is a need to reduce the number of visits into a resident room to reduce the risk of spread. Time changes will need to be determined as appropriate by working with the prescriber and pharmacist.

The home will continue to use the faxing method to get medication orders to the pharmacy in a timely manner. Nurses may need to communicate the need for priority orders with the pharmacy directly by phone after faxing orders, in times where there are limited pharmacy staff and/or increased demands to ensure that resident needs are met.

The physical delivery of the medication to the home is anticipated to continue, although there may be changes to the way medication is delivered if the home is unable to accept visitors for example. The home's processes will need to also consider the pharmacy provider's emergency protocols. Medications may be delivered to the home's entrance. The driver would contact the RN on duty to accept and sign for the medication deliveries.

In the event of resident moves to the temporary relocation site, the pharmacy provider will need to be informed of this move. The Director of Nursing may need to work with the pharmacy provider to supply additional medication supplies such as locked medication cart and laptop for eMAR. In the event this isn't possible in an urgent situation, the computer on wheels may be used from a home area as well as a locked treatment cart on a temporary basis.

The dedicated relocation space is the home's auditorium on the 3rd floor. The locked storage room at the front of the auditorium would be temporarily set up as the medication room. An additional lock or change of lock may be required to limit access to this room during an emergency.

A medication fridge with a thermometer will need to be set up in that area to store medication that need to be refrigerated.

If the auditorium is used as a relocation zone during an emergency, the home may need to request additional emergency medications to store in this area from the pharmacy provider.

In the event a resident is moved to a location off site, out of the home's care such as with family or friends, the home will work with them to ensure that they will continue to receive the medication that is prescribed during their temporary absence.

The home area nurse will follow the procedure for providing medication to residents and/or family during outings, which includes providing the pharmacy with notice to ensure that medication is provided for the anticipated time away.

The nurse will list the medication and provide instructions. The nurse may consider providing the resident and/or family with a paper copy of the MAR to assist them in following the administration times.

The home will work with the pharmacy provider to assist the resident and/or family in obtaining further medication if the absence is extended, such as making arrangements for the medication to be picked up from the home or delivered to their home.

The home's director of nursing will work with the RPN initiative to ensure that the government stock medication supply remains stable, and to report any issues with supply chain issues. The home may consider obtaining some of the medication from the pharmacy provider in the event of government stock issues.

The home will work with the pharmacy provider to obtain medical treatments related to the disease of concern; including any protocols for the medical director, physicians and nurse practitioner to use when prescribing treatments for residents.

The home will work with the public health unit to obtain vaccines for residents if applicable. Consider contacting the health unit or verifying the website for any new forms and protocols to follow to obtain vaccinations during the emergency.

Appendix J: New Immunizations and Treatments

Although it may take a long time, new vaccines and treatments are often developed as a way to respond to and fight against new pathogens causing significant public health illnesses of concern.

The goal will be to implement all applicable prevention measures available prior to vaccine availability to reduce the risk of pathogens of concern entering the home and infecting the residents who are most vulnerable.

The home will promote prevention and treatment options as they are made available during these times, per public health and ministry recommendations.

The IPAC coordinator will share any updates with the medication management team as it relates to new immunizations or treatments as they become available to the residents and/or staff.

The home's medical director and pharmacy provider will be included in the development of policies, procedures, protocols, directives developed as a result of new immunizations and treatments.

The medical director, physicians, nurse practitioners will work along with the pharmacists to determine eligibility for treatment based on medication specific guidelines.

The home will facilitate access to prevention methods such as offering publicly funded immunizations within the home to residents, employees, volunteers and families as required.

The home may utilize the assistance of local community partners, such as EMS, to assist in vaccine delivery in home when internal resources may not be enough or when specific vaccine storage and delivery needs cannot be accommodated in the facility.

If treatment is not available to be offered within the home, such as treatments only available in the hospital setting or on a designated pandemic unit, the home's medical director will consult with the local treatment providers when a resident is deemed eligible for, and consents to the considered treatment off site.

The home will facilitate any transfers to local healthcare services as required when treatment is deemed necessary but not available in house.

Immunization clinics will be held internally for employees seeking new vaccines as long as the home has the capacity to store the vaccine internally.

All available community immunization clinics will be promoted to enhance access.

Ongoing need to maintain disease specific treatment protocols will be determined post emergency. Where there is ongoing risk of outbreaks related to pandemics/endemics, medical directives and protocols will be reviewed and approved for use at based on public health recommendations.

For all existing immunization and treatments related to diseases of public health significance, please refer to the home's procedural manual.

Appendix K: Outbreak Management Team

The outbreak management team will meet as soon as an outbreak is suspected or declared during the enactment of this emergency response plan.

The following are meeting guidelines and considerations for the OMT to use while managing an outbreak.

Initial Outbreak Meeting

- Confirm an outbreak exists and ensure that all members of the team have a common understanding of the situation.
- Adopt a working case definition or criteria that will be used to identify residents or staff with illness caused by the pandemic strain. The case definition for residents may differ from that developed for staff.
- Residents / staff who meet the case definition will be considered a case regardless of the results of laboratory testing unless another diagnosis is confirmed.
- Review the control measures necessary to prevent the virus from spreading and confirm the IPAC Coordinator (or designate) who is responsible for ensuring that agreed upon control measures are in place and enforced, and for modifying control measures depending on the epidemiology of the pandemic strain.
- Identify/confirm the appropriate signs/information to be posted in the Home, and the appropriate locations.
- Institute exclusion policies and the staffing contingency plan.
- Enforce proper use of PPE.
- Report the outbreak to appropriate people/institutions outside the Home such as:
    - Medical Director and attending physicians.
    - Other health care providers
    - Families of residents in the home
    - Ministry of Long-Term Care

    - Implement pandemic communication plan (e.g. distribute internal communications for residents/ family and staff groups; determine if education sessions are required for staff members and who will conduct them; confirm how and when daily communications will take place between the home and the public health unit; ensure that contact telephone numbers are available 24 hours a day, seven days a week for both the TBDHU and the Home.
- Clarify the role of the TBDHU, and the availability of public health services, including laboratory testing.
- Decide how frequently the OMT will meet and set next meeting.

All meeting minutes will be documented on the “outbreak minutes blank” created in June 2022.

Meeting minutes will be shared with all who attended the meeting.

‘**Monitor the Outbreak/Conduct Ongoing Surveillance**

Outbreak monitoring includes ongoing surveillance to identify new cases and update the status of ill Residents and staff. During a pandemic, Pioneer Ridge will continue to report cases of respiratory illness and deaths to the public health unit. The ICP or designate will update the pandemic outbreak reporting forms and submit them to the TBDHU as required.

Assess Resident Care Needs

Daily Assessment of Residents is required.

A Point of Care Risk Assessment (PCRA) must be completed by all healthcare workers with every resident interaction.

Registered Nursing staff should assess Residents care needs in order to identify Residents who could be discharged to family members in the event of an outbreak.

Identify Residents at highest risk of complications from respiratory infection and try to limit the risk of exposing them to the pandemic strain.

Master Lists of Residents and any changes should be kept up to date.

Essential Service Considerations

Pioneer Ridge will likely be short staffed and will have to focus on delivering essential services. Department Managers must identify:

Services that MUST be maintained to provide care and protect Residents health.

Services that could be reduced or curtailed.

Services that can be postponed or cancelled.

Identify Priority Group for Access for Antivirals and Vaccine.

Direction will be taken on Priority Groups from the Ontario Public Health.

Identify Required Supplies/Alternative Supply Chains

It is recommended we should identify the type and quantity of supplies we will need, purchase and maintain a one-month stockpile. See supplies and equipment template developed by MLTC.

During a pandemic, traditional supply chains may be disrupted.

Develop a contingency plan in the event of a power failure. Ensure all refrigerators containing vaccines are powered by generator.

Pioneer Ridge will need to:

Talk to suppliers about their ability to deliver supplies to the home during a pandemic.

Review systems in place to ensure adequate supplies (e.g. environmental cleaning supplies, food, medications, oxygen concentrators)

Establish relationships with alternative suppliers/sources, including equipment suppliers, food suppliers, medical suppliers, pharmacies, oxygen suppliers

Human Resources Considerations

Develop a staffing reallocation plan for volunteers, family, alternate sources of staff according to patient care complexity.

Visitors, alternative staff will follow home policies and procedures for immunization and anti-viral prophylaxis.

Exclusion Policy

During a pandemic if there is no vaccine, non-immunized staff will NOT be excluded from providing care, provided they wear appropriate PPE and perform frequent hand hygiene as with all staff.

Staffing

Must consider the varying levels of available staff during the pandemic due to illness, family responsibilities, unwillingness to work or take antivirals if applicable, and staff with medical contraindications to antivirals, immunocompromised.

Adequate Staff/Patient Ratio

Pioneer Ridge will likely experience staff shortages and may have to take measures to continue to provide care for residents.

List of retired RNs, RPNs, PSWs and other service workers.

Training of support staff who could assist ADL i.e. feeding, dressing etc.

Direct care staff who have more skills can be trained to take on more responsibilities within their scope of practice. Home care and home support agencies who may be able to provide workers with appropriate skills.

Strategies that could be used to increase capacity, i.e. extending working hours, calling staff back in.

Supports for staff so they can come to work, i.e. childcare, accommodations, transportation.

Appendix L: Protection of HCW/Management of Exposures

Protection of Health Care Workers

During a pandemic, before an effective vaccine is available, the risk to health care staff of becoming infected will be similar to the risks faced by the general population.

This may be due to:

- The ease with which respiratory illnesses can pass from one person to another.
- The large number of people in the community who will be infected.
- The high risk of community spread due to social gatherings, travel, events, etc.

The Risk in the Workplace

Respiratory illnesses are primarily transmitted directly from person to person when infected people cough or sneeze, and droplets from their respiratory secretions come into contact with the mucous membranes of the mouth, nose and eyes of another person. This is known as droplet spread.

Many respiratory droplets can survive 24 to 48 hours on hard non-porous surfaces, 8 to 12 hours on cloth/paper/tissue and 5 minutes on hands.

This means people may acquire an illness indirectly by touching contaminated hands, surfaces and objects. This is known as droplet contact spread.

Whether or not respiratory viruses can be spread via airborne transmission is controversial but, according to the Canadian Pandemic Influenza Plan, “there is no evidence of such transmission in humans”. In ordinary circumstances, respiratory viruses are not spread through airborne routes.

Airborne transmission is however possible, in cases where healthcare workers are performing high risk procedures that generate aerosols into the surrounding air. Examples of these in a LTC setting may include oral suctioning, nebulized therapies, aerosol humidification, and use of CPAP.

Duty to Provide Care and Responsibility to Protect Workers

Health care workers have a professional and ethical duty to provide care and respond to suffering.

Society has an ethical responsibility to support health care workers who often bear the greatest burden and responsibilities in continuing to work to protect the public good.

During the initiation of this plan, employee concerns about their personal health and safety, as well as the health and safety of their own may cause them to weigh their duty to provide care against competing personal obligations.

Under the Occupational Health and Safety Act, Pioneer Ridge has a legal obligation to take all reasonable precautions to protect workers while in the workplace; this includes putting measures in place to protect the health and safety of workers during pandemics, endemics and outbreaks of diseases of public health significance.

Employers in health care facilities have a duty to establish measures and procedures to protect workers, including:

- Measures to prevent and control the spread of communicable diseases.

- Provision of personal protective equipment.
- Immunization policies.
- Use of appropriate cleaning and disinfecting supplies.
- Measures to prevent needlestick injuries, including disposal of sharps.
- The safe handling of soiled linen and disposal of trash and biomedical waste.

Routine practices are in place in the home to protect health care workers, such as hand hygiene, use of gloves and personal etiquette expectations such as covering coughs/sneezes and staying home when sick. Consistent use of routine practices is of upmost importance.

Pioneer Ridge is committed to working closely with and include the joint health and safety committee in meetings related to the use of this emergency response plan; including outbreak management meetings. The joint health and safety committee includes the Jasper Support Program. At least 1 management and 1 union representative from the JHSC will be invited to attend these meetings.

During the activation of this emergency response plan, workers will be asked to do the following to protect themselves and others:

- Be screened prior to entry into the home.
- Stay home if presenting with symptoms or report a new onset of symptoms immediately while at work.
- May be asked to undergo any testing as required.
- Always wear a medical mask while working, unless eating/drinking on breaks (respiratory).
- Wear eye protection in resident care areas (respiratory).
- Follow additional practices/use of PPE as posted outside resident rooms.
- Report any signs and symptoms of illness while at work immediately to their supervisor or RN on duty.
- Follow the plan for staff cohorts – avoid contact with staff from other care areas.
- Be extra mindful and diligent with hand hygiene practices; including encouraging residents to perform hand hygiene.
- Obtain recommended immunizations in accordance with public health recommendations.
- Perform a personal risk assessment prior to interactions with residents.
- Inform themselves of any residents with symptoms prior to entering their room or personal space.
- Instruct colleagues, residents, visitors in the proper use of PPE and hand hygiene practices.
- Seek additional training from nurses, managers and/or IPAC coordinator as required.
- Keep up to date with N95 Mask Fit testing; report need for re-testing to supervisor if over 2 years since last test or changes in weight which may have affected the fit of their mask.

Pioneer Ridge's outbreak management policies as they related to exclusion of staff will be used to manage known risk factors. Public health guidance and directives will be used to guide decision related to exclusion from work in the event of new illnesses of concern.

During the initiation of this plan, any staff with symptoms or work in other healthcare facilities may be excluded from work. Employees are to communicate with their direct supervisor/manager for guidance.

Management of Exposures

Even when employees follow the IPAC measures outlined in this plan, there is always risk of exposure to communicable diseases in a healthcare facility which may result in illness.

If an employee is exposed to an active case in the home without PPE, they may be asked to self isolate at home and be tested.

If an employee is exposed to an active case in the home while in full PPE, they may continue to work and monitor for symptoms.

Any illnesses resulting from exposure or working in an outbreak area need to be reported to the employee's supervisor.

RNs will screen sick calls for symptoms, and report anyone who is calling in sick as a result of symptoms meeting case definition on the RN screening form, which will be provided to their direct supervisor.

Supervisors and Managers who receive sick calls directly will also screen for those with symptoms with a potential for meeting case definition. The manager questionnaire will be used by managers for all employees identified as symptomatic, close contact or positive.

RNs, managers and supervisors receiving sick calls will inform the person to self isolate and get tested, and then they will inform centralized scheduling to begin shift replacement.

Managers will be responsible for following up with their direct reports to obtain additional information to determine if the illness was acquired in the workplace.

If illness was acquired in the workplace, the manager/supervisor will be responsible for collecting data in order to submit the following:

- A report of injury to HR for WSIB reporting
- Mandatory reporting under the Fixing LTC Act and Regulation
- Mandatory reporting under the Ministry of Labour/Occupational H&S Act
- Completion of a TB483 upon return to work

Exposures will be managed on a case-by-case basis. Current guidelines and directives provided under the ministry or public health authorities will be used to guide decision-making regarding return-to-work dates, or test to work procedures.

Appendix M: Resident Cohorting Plan

When there is a pandemic, endemic or with local outbreaks of diseases of public health significance, the home will implement the use of this resident cohorting plan.

All residents will be limited to activities on their home areas as much as possible.

Minimal movement of residents between home areas will be implemented. Residents visiting other areas of the home and outdoors will be kept in the same cohort as their home area.

Mixing of resident home area cohorts will not occur unless the activity is able to accommodate at least 6 feet of distance between individual cohorts.

The same will be asked by residents, families and visitors, to stay a minimum 6 feet apart from other groups when visiting in common spaces such as outdoor spaces.

During outbreaks in the home area, activities will be limited to 1:1 activities and/or cohorts from the right and left court hallways.

The doors of each hallway may be closed to assist in creating a physical barrier between cohorts. This approach may also be used to divide the affected resident home area into smaller cohorts within their individual hallways using the fire doors.

Cohorting of residents and staff will normally happen at the same time. The home will do their best to limit staff movement between resident cohorts during times of outbreaks on the home area; based on capacity and staffing.

During outbreaks, residents will be limited to the affected home area and will not be permitted to move between home areas to reduce the risk of exposure to other residents, staff and visitors. Each individual case will be assessed based on risk vs benefit in times when ethical considerations are brought forward.

Residents who require urgent medical attention are able to leave the home area. Nursing staff will need to ensure that there is communication with EMS and the receiving facility when a transfer is required, to inform them of risk related to exposure/outbreak and/or infection.

During declared outbreaks, non urgent medical appointments may be rescheduled. In non outbreak situations, the nursing team will work together with the resident and/or POA/SDM to determine measures to take to reduce the risk when they are attending appointments out of their cohort.

When residents are returning from an absence from the home during a time when the resident cohorting plan is active, measures will be taken to monitor for symptoms and initiate testing and/or isolation as required based on the disease of public health significance.

Appendix N: Section Specific Considerations

Nursing Considerations

The purpose of this document is to help guide the nursing management team in the event of an IPAC emergency. It includes things to consider when preparing to address a new illness of public health concern that is declared a pandemic or outbreaks of communicable illnesses where control measures may need to be considered to protect the residents of the home.

Some of the considerations are based on the home's experience in implementing additional measures to minimize risk during the covid-19 pandemic in 2020.

The illness/disease of concern

Consider the type of illness/disease of concern. What are the symptoms? How is it transmitted? Is it known to spread rapidly?

The measures we take will depend on the infectious agent of concern. If not much is known about how it is transmitted, we may want to consider implementing more enhanced measures to protect the residents and staff.

New respiratory illnesses are often the most concerning as the mode of transmission may vary. Consider implementing the use of universal masking with medical masks immediately when respiratory symptoms are present on the resident care area.

Any resident who has 2 or more new respiratory symptoms should be isolated and placed on additional precautions until the causative agent is known.

The use of other measures such as cohorting residents and staff should be considered. Home areas may be split into 2 sections, the left and right court, to reduce the risk to others.

Limiting traffic to those who are providing essential care and/or services when new symptoms are identified/suspect outbreak.

Staffing

Look at your current staffing levels. Are you able to meet the resident's needs if an outbreak were to be called on the home area?

Are there any recommendations to limit staff to one organization? If so, determine which staff/how many staff may not be able to continue to work for this home.

Is there a risk of staff being unable to attend work due to other risks such as chronic medical conditions, limitations related to childcare, etc.?

Is there a risk of staff becoming ill? If staff become ill, how long will they need to be off work?

While considering the risks related to staffing levels being affected by the illness of public health concern, list other alternatives that may be implemented in the event of a staff crisis.

Alternatives may include:

- Internal resources that may be able to assist in duties such as delivering meal trays, assist with meals, doing fluid rounds, etc.
- Corporate resources such as HR to assist in recruiting and hiring efforts.

- Displacing staff from the corporation to assist by providing companionship, activities, filling up outbreak supplies, delivering meals, etc.
- Agency staff
- Are there any resources that can be obtained from healthcare partners?
- Are there any modified workers that can be displaced temporarily from within the home and externally, such as EMS to assist in testing, vaccination efforts?

Review the staffing contingency plan within this emergency plan for further nursing specific plans and schedules.

Healthcare Partners & Service Providers

There are many healthcare partners and service providers that attend the home regularly. Consider whether the following services will be affected by this emergency or if measures are needed to continue to allow services to flow.

Laboratory services:

- Are there any restrictions that will affect the technician's ability to come into the home/resident rooms to collect blood sampling as scheduled?
- Should lab services be limited to necessary/critical labs to limit the number of residents the technician visits each week?
- Can the lab specimen collection continue weekdays? Will we need a process to have the lab specimens sent to the service provider at the door vs allowing them to enter the home?
- How will we receive the lab results? Urgent lab results from outbreak/pandemic related testing may be faxed to the confidential line in the business office.
- Determine if the service provider has their own procedures to follow because of the disease of concern.

Foot Care/OT/Dental Hygiene/Other:

- Families may have contracted service providers such as foot care providers, dental hygienists, chiropractors, physio, etc. Consider who may be receiving these services in the home and reaching out to communicate any steps the home is taking to minimize risk to residents.
- Consider that these providers may also have their own processes in place and restrictions.
- Families could work with you to assist in the communication as they contracted the services.
- OT services such as wheelchair/seating assessments may or may not be affected. Work along with restorative care regarding the steps to follow to reduce potential risk when OT services are required.
- Our physio program is contracted to a service provider. The PT is normally shared between homes; therefore, there is a potential for this service to be interrupted in some way. Consider virtual PT assessments if the physiotherapist is limited to another home. The PTA is normally assigned to work in 1 home; therefore, they would most likely follow our procedures.
- The pharmacy provider may have limitations when it comes to delivering medication in the home. Consider moving deliveries to the back door and have them contact the RN cell phone to pick up the medication during their twice daily delivery times.
- The oxygen concentrator service provider may have specific requirements to follow as it relates to the exchange of concentrators. Verify if there is any anticipated change in their process.

- Consider providing education/instruction on home specific IPAC measures/policies to services providers who attend the home regularly.
- Nurse led outreach NPs may be affected as they tend to be assigned to a few Organizations. Determine if there will be a change in their process as they are employed by the TBRHSC.
- Physicians may reduce the number of in person rounds based on the risk and whether they practice within multiple healthcare facilities. Consider facilitating virtual appointments if required.

Vaccinations/Treatments

With any new disease may come a new vaccine or treatment protocol. Nursing will want to determine whether there are any known vaccines and treatments available, and if so, what do these look like.

Will these be available to the residents of the home? Who will be eligible?

How will these be obtained? Do we have the capacity to store these vaccines in the home? Can these be stored in our fridge with other vaccines between 2-8 degrees? How long do the vials last after opening or mixing?

Do we have enough supplies on hand to provide vaccinations? Consider the number of needles and syringes on hand – and how the vaccination is provided such as pre-mixed, unmixed, pre-mixed and in syringes, etc. A mixing solution will be required for vaccines that require mixing in the home.

The home will need to obtain information from the public health recommendations regarding vaccination use, eligibility, etc. Once these are confirmed, the home will need to create a medical directive in collaboration with the medical director to enable the nurses to provide the vaccinations to residents, and staff as applicable.

During the covid-19 pandemic, residents were approved for access to vaccines first, followed by healthcare providers. The vaccine was limited to be provided by certain healthcare partners; therefore, these may be factors with future pandemics.

New treatments protocols may be developed to treat an illness such as an antiviral. It is important for the nursing management team to work with the medical director, nurse practitioner and pharmacy provider to develop treatment protocols and implement medical directives for their use as applicable.

The treatments may vary greatly, in some cases, treatment may be available for all residents similarly to influenza antivirals or they may only be available to residents who meet a specific criterion as seen with the covid-19 treatments.

The team will also need to consider that some staff and residents may refuse immunizations and/or treatments, therefore plans for how to manage the unvaccinated will need to be considered.

Postmortem/Funeral Home Considerations

Verify whether there are any special requirements due to the pandemic for reporting deaths to the Chief Coroner’s Office. Different forms may be required deaths related to the pandemic / disease of concern.

Consult with local funeral homes regarding any change in their process for transferring bodies to the funeral provider such as special handling considerations and whether labelling is needed.

Determine if there are additional recommendations/precautions required for those handling a resident postmortem as well as any risk to loved ones if coming to see the body after passing.

Outbreak Management

Outbreak management is covered in another section of this emergency plan, but there may be additional considerations as indicated below:

- Consider providing the RNs and Nurse Managers a refresher on outbreak management, including line listing, case management, additional precautions, testing methods.
- Determine a process to complete unit-wide testing on all residents if required such as dedicating a cart for testing, with supplies readily available. NUSWs can prepare the lab requisitions and labels on specimen collection containers in advance to facilitate the process.
- Review processes for cohorting staff and residents.
- Initiate the use of the left court living rooms for staff breaks.
- Consider the use of the back stairwells on each home area for staff who go outside the home on breaks.

Resident-Specific Needs

Consider how to manage residents who have specific needs such as wandering, smoking, etc. in collaboration with the nursing teams.

Determine what risks may be associated with permitting these individual needs to continue and measures that can be put in place in a plan of care that will permit safe, monitored, and controlled activities.

Scheduled medical appointments may need to be postponed depending on the situation, and whether they are non urgent vs urgent in nature. The NUSW may contact outside medical providers/organizations to determine their limitations.

Uniform Laundry Service

Consider offering a uniform laundry service for staff to be able to change uniforms at the end of their shifts. They would bring in a number of uniforms that would be laundered for them on site.

Emergency Services

Emergency services will likely not be affected by the pandemic as they will still need to access the home.

As with any communicable disease, the RNs will need to be reminded to clearly indicate when someone is infected with a pandemic related illness when contacting EMS, or when police or fire services need to attend a specific area.

The emergency service providers will have their own procedures to follow as well.

Governing/Regulatory Agencies

Review any new CNO news regarding any changes that may impact nursing practice.

Home & Community Care Support Services (formerly LHIN) – consider whether there are opportunities available for residents to receive care off site with their families and any funding to support this.

Any changes regarding the management of admissions and transfers to consider?

Human Resources

Consider whether there will be changes related to the reporting of workplace illnesses and WSIB documentation.

Consider how sick time will be managed. Determine the number of days employees will need to stay away from work if affected by disease of concern.

Consider how to manage those who cannot work due to chronic diseases, age, childcare, as experienced during the covid-19 pandemic.

Resident Counsellor

Admissions and transfers may be affected by the pandemic or disease of concern.

If visits and tours are limited/restricted, the resident counsellor may consider providing these virtually.

Communication with the new resident and/or SDM may need to be offered in different ways based on their ability and resources during the pre-admission process. Consider telephone, virtual and email communication methods if required.

Admissions will be placed on hold in the event of an outbreak on the home area the new resident would have moved to; or in a facility-wide outbreak.

Admissions and transfers will not be permitted if a resident is coming from an area that is in an outbreak of the disease of concern.

Admissions and transfers may be permitted to move forward in some cases, based on the MLTC and public health guidance.

Nutrition & Food Services Considerations

Pandemic nutrition and dietary routines have been created to meet nutritional requirements of residents and staff while still providing the residents an enjoyable meal service with the best nourishment possible according to their health and dietary requirements.

Regulations outlined by the Ministry of Long-Term Care are integrated into the routines. All meals will be served to ensure physical distancing of six feet apart. Plexiglas dividers will be installed to provide an added barrier if the table permits. A list of residents who require eating assistance and are at risk of choking will be in the server for reference. A seating chart will be developed to reflect where residents have been temporarily relocated to for mealtimes. This may include the utilization of the activity room or other areas where supervision can be provided during mealtime.

A 7-day emergency menu order guide will be initiated if staff availability falls below 50%. This will enable existing staff to continue to provide meal services for the residents.

Supply and demand of food and pantry items will be monitored and sourced from secondary suppliers if needed. “No touch” delivery of required supplies will be implemented (items will be unloaded from the delivery truck onto the loading dock where homes staff will distribute).

Meal Service for Residents

Residents will be assisted to their designated dining areas for their meal by staff on the home area (staff include PSW, RPN, RN, Pandemic worker, Deployed worker, Home Support Staff).

The Residents will be assisted to perform hand hygiene prior to being seated at their designated dining table and be provided a clothing protector if requested or required.

Staff who are helping residents will be required to wear appropriate PPE and adhere to appropriate infection control procedures such as hand hygiene.

If a resident is symptomatic and is isolated to their room, they will be provided with tray service while utilizing PIDAC Best Practices which includes utilization of regular dishes, utensils, and trays (these items can be effectively decontaminated in the commercial dishwashers). Once the resident is finished their meal, staff will disinfect the used tray with disinfecting wipes prior to return to the dining room.

If the auditorium is being utilized for residents in isolation, the Home Area 3 Kitchenette will be designated to provide the tray service for those residents.

Meal Service for Staff

Menus will be adjusted to utilize excess inventory that is on hand due to cancellations of catering events or other cancelled services.

Social distancing will be implemented in the coffee shop.

Staff will not be allowed to utilize the coffee shop area for meals unless they don't have a designated break area. Meals for staff are to be consumed in designated areas on their home areas. Take out will be made available for staff to purchase in the coffee shop and eat in their designated area.

Additional cleaning of the coffee shop area will be implemented.

Meal Service for Jasper

Meals will be delivered via cart to the link. Jasper staff will distribute the meals to client's rooms as requested.

The delivery cart will be cleaned upon return from Jasper link.

Depending on availability, purchase items of necessity to be stocked on site for a temporary store for clients to purchase said items.

Meals on Wheels

The Meals on Wheels Home Support Program provides individualized, full-course meals prepared by Pioneer Ridge dietary staff for people in need of assistance in our community. This service helps individuals maintain independence.

The service will continue to operate using a contactless delivery system.

Meals will be placed in disposable containers. The containers will be placed inside the delivery bags.

Upon return to Pioneer Ridge, the bags will be thoroughly cleaned and disinfected before being stored until next use.

The food menu will remain the same as usual (depending on availability of supplies).

NFS Specific IPAC Measures

Hand washing audits increased in all areas to ensure proper hand washing is completed when:

- Serving or cleaning dishes
- Taking out garbage
- Clearing tables or bussing dirty dishes
- Touching clothing or aprons
- Touching anything else that may contaminate hands, such as un-sanitized equipment, work surfaces, or washcloths.
- Sanitize Residents hands before and after meal service.

Ensure approved chemicals are used at the right concentration:

- Quat – 200 –400 ppm
- Chlorine (Diversol) 100 ppm
- Play close attention to the dish machine to ensure it remains in good working order (correct wash/rinse temperatures)

Enhanced cleaning routines of frequently touched surfaces

- Tabletops, edges, chair arms, backs
- Tabletop plexiglass barriers
- Counter tops, equipment surface.
- Handles, knobs, buttons
- communal items, such as salt and pepper shakers, condiments or centerpieces or removed.

Designated Relocation - Auditorium

- Tray service from closest Home Area kitchenette (HA3)
- Use disposable products only including paper trays if possible.
- Keep all waste in residents' rooms until disposed of, do not gather with other waste.
- Meal selection process for isolated residents put into place utilizing temporary location staff.
- Enhanced cleaning routine for meal delivery cart (Quat – 400ppm)

Retail Service

- Coffee Shop will be closed to visitors while visitor restrictions are in place.
- Designated break area for staff **not** cohorted to a Home Area can eat in the Coffee Shop
- Plexiglas dividers will be installed on the tables to provide an added barrier.
- Chairs removed from tables to allow for social distancing (6 feet)
- Plexiglas dividers will be installed at cash register counter to provide an added barrier between cashier and customer. Cash payment will be discouraged.
- Enhanced cleaning routines for frequently touched surfaces

In Dining Rooms:

- Remove and/or spread-out tables and limit the number of people at each table, so that a minimum of 6 feet is between each resident.
- Use physical barriers between residents where 6 feet distance is not achievable.
- Use disposable products, if possible, for residents who are symptomatic and/or isolated.
- Keep all waste in residents' room until disposed of, do not gather with other waste.
- Enhanced cleaning routines of frequently touched surfaces

Within an outbreak area

- Tray service only; ensure 7-day supply of disposable dishes are available or accessible.

- Use disposable products only including paper trays, if possible, for residents who are symptomatic and/or isolated.
- Keep all waste in residents' rooms until disposed of, do not gather with other waste.
- Meal selection process for isolated residents put into place utilizing Home Support Workers.
- Enhanced cleaning routines of frequently touched surfaces.

Cohorted to floors:

- FSWs working on floors start the day in the Main Kitchen completing assigned duties before going to their assigned floor.
- FSW shifts cohorted to their floor for the remainder of the day; return carts to Main Kitchen at the end of their shift using the service elevator.
- Staff meals for cohorted staff delivered to each floor to help reduce outside exposure including staff leaving/returning for meals (Staff meals supplied by the Home depending on budget and/or funding).
- Portering shift added to deliver food/supplies to staff cohorted to floors.

Scheduling:

Master rotations:

- 4 FT FSWs cohorted to one floor each
- 5th FT FSW assigned to a different cohort with a 24 hour stay period between cohorts.
- Each PT FSW rotation cohorted to one or two floors; assigned to a different cohort with a 24 hour stay period between cohorts.
- Short call booking (0-7 days): floor assignments adjusted to allow for cohorting to one floor as possible.
- CS, MOW FSWs may be assigned to a cohort after completing the CS/MOW shift within the same 24 hours.
- Employees **are not** assigned to a different cohort within the same 24 hours; assignments adjusted as needed.
- All cook rotations and pot washer cohorted to Main Kitchen
- Storekeeper cohorted to Main kitchen and Central Stores; Supplies delivered from Central Stores will be dropped off at the entrance of each home area.
- Assigned backup person for placing food orders or picking up supplies in the event the Storekeeper/Nutrition Manager is unavailable.

Schedules posted in department and available in E: Food Service/Scheduling

Reduced staffing:

- In the event FSW staff are reduced to 60% due to illness, staffing for resident meals takes priority; meal service for ancillary programs adjusted by utilizing available staff from other departments (i.e. Meals on Wheels) or Nutrition Manager, Supervisor or RD
- In the event cooking staff is reduced to 50% due to illness, 7-day emergency menu initiated for all meal service.
- The FSM will report staff with illness/symptoms to the IPAC coordinator.

Therapeutic Recreation

Therapeutic Recreation is about bringing joy and quality of life to LTC home residents. It is about maintaining each resident's sense of meaning and purpose, their capacity for happiness, build relationships, self determination, and autonomy by making necessary adaptations to recreation and leisure opportunities that will allow for participation no matter what ability or limitation the resident may have.

The Therapeutic Recreation staff will allow for the continuation of programing within the restrictions set forth by the Ministry of Long-Term Care. In the event the public health mandates/guidelines state there will be no group programing, one to one programs will be implemented on the home area with the designated therapeutic recreationist assigned to that particular home area. Creative delivery of programs where residents are engaged while maintaining safe social distancing will be implemented. The use of technology will be used for music integration, visualization, and conversation.

Virtual visits using video conferencing such as Zoom or Teams and IPads will be implemented to ensure resident families can connect. Window visits will be implemented for families who do not want to physically enter the building.

The progression of group activities will be based on the correspondence from the MLTC. Under the directives, more group activities will be allowed with capacity restrictions. Cohorting of residents will be maintained based on ministry directives/public health guidance.

Therapeutic Recreation IPAC Measures

Staff will stay on their assigned home areas to conduct programing. If additional staff are required, a request will be made via the Therapeutic Recreation Supervisor.

Therapeutic Rec. to inform or cancel the following: volunteers, Hospice Northwest/entertainment, outings/transportation, maintenance set ups for auditorium or other areas, dietary requisitions for auditorium programs, contractors-Fish tank.

During summer months, garden volunteers will need other arrangements for toileting facilities- such as renting an outdoor “porta-potty”.

1 TR staff assigned to each home area; part time and casual staff cover on days when staff off-24 hours in between shifts, when working on different home areas, hire casual staff as required.

Each home area has their own individual program supplies and 1 T.R to pick up additional supplies for their activities from storage room in non-resident area, following all I.P.A.C measures, at start of their shift, prior to entering their home area. The supervisor will shop for monthly supply needs.

If there are deployed staff: they will be assigned to a home area. Resident deliveries to each home area will be picked up from screening area at start of their shift, prior to the deployed worker going onto their designated home area.

In the event that there are visitor restrictions, alternative visiting will be offered:

Window visits - Residents follow all IPAC measures when leaving home area, wearing a mask to the window area, remove mask for visit, then reapply mask prior to returning to home area. TR staff or designate sanitize telephone area upon leaving.

Virtual visits - TR staff or designate will book appointments for facetime/skype/google zoom.

All program supplies are sanitized prior to and after resident use and stored in appropriate areas.

TR supervisor communicates with T.R/deployed worker via texting, phone or email.

Monthly recreation calendar will be on a week-by-week basis or day by day, dependent on resident program size or if residents are isolating.

Small group programs or 1:1 programs only following ministry directives or public health recommendations

TR supervisor to report to IPAC for line listing, any staff calling in with related symptoms.

1 TR designate to enter T.R office prior to shift (preferably home area 1 T.R.) to check phone messages, return calls, as needed.

The TR supervisor will determine whether any registered volunteers attending the home will need to review education regarding the any new procedures that will affect them, IPAC measures and personal protection.

Environmental Services

The Environmental services department includes housekeeping, laundry, facility maintenance, and equipment maintenance. The environmental services department is responsible for the safety and cleanliness of the home. This includes traditional janitorial tasks like mopping and dusting, but also requires an understanding of proper handling and disposal of biological waste. They are an important first step in the prevention of the spread of germs. The practices outlined have been created using information from Health Canada, PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition (April 2018).

Enhanced Cleaning Protocols

The approach to cleaning the facility will vary depending upon the area to be cleaned.

Areas where clients/patients/residents receive care, waiting areas, dining rooms, activity rooms, medical equipment and supplies, storage, medication preparation areas, nursing stations and other areas involved in the provision of health care will receive enhanced cleaning.

Public areas such as lobbies; offices; corridors; elevators and stairwells, doorknobs, light switches will be cleaned on a scheduled rotation.

Enhanced environmental cleaning reduces the number of infectious agents present on surfaces, thus reducing the likelihood of transfer of microorganisms from one person or object to another. Increasing the frequency and thoroughness of cleaning, along with the use of disinfectants will help decrease the possibility of the spread of organisms resulting in the less likelihood of an outbreak.

Frequency of Cleaning

High-touch surfaces are surfaces where individuals come into contact with their hands on a frequent basis. Some of these items include (but are not limited to) doorknobs, elevator buttons, telephones, call bells, call bell, bedrails, light switches, toilet flushes, BP machines, foot boards on the beds, lift controls, floor lifts, computer keyboard, and phones. These surfaces should be cleaned more frequently to decrease the risk of transmission of viruses.

Low-touch surfaces are those that have minimal contact with hands. Examples include (but are not limited to) floors, walls, mirrors, and windowsills. These areas require cleaning on a regular basis but a less frequent basis as opposed to high touch surfaces. If the low touch surfaces are visibly soiled, however, they should be cleaned immediately to avoid any transmission of germs.

Additional things to consider:

Staffing levels and human resource requirements will need to be assessed daily to ensure proper cleaning of the home can be done. Staff should be deployed according to highest need areas.

Housekeepers should prepare the required cleaning equipment and supplies prior to entering a room and putting on any required personal protective equipment. Do not bring cleaning carts into the

resident room. After performing hand hygiene and putting on the required personal protective equipment, the room can be entered.

Cleaning Processes

All staff who will be involved in cleaning throughout the home will be trained in best practice following the IPAC Environmental Services Cleaning Training. Areas will be audited on a regular basis. Disinfectant cleaner that is used will be identified as Percept spray or Accel wipes.

Best Practice – Percept Bottle Spray vs Accel Wipes

Percept-Spray Bottle and Rag:

A hospital disinfectant concentrate based on proprietary Accelerated Hydrogen Peroxide (AHP®) technology.

Disinfects in five minutes and is a non-food contact sanitizer in 30 seconds.

Excellent user profile, active ingredient breaks down to oxygen and water.

Meets blood borne pathogen standards for decontaminating blood and body fluids.

Accel-Wipes:

3 Minutes, Bactericidal, Virucidal, Tuberculocidal, Fungicidal

30 Seconds! Broad-Spectrum Sanitizing

One-step cleaner and disinfectant with a pleasant odour.

Sustainable - Active ingredients break down into oxygen and water after use.

Remember to use areas that require fast drying time and Percept in areas that will have time to sit and dry. Some suggestions below

Cleaning/disinfecting done by Housekeeping

Accel wipes will be needed to clean in these common areas:

Door handles in common areas

Railings in common areas

Phones

Keys

Computer keyboards and mouse

Sink taps in nursing stations

Hand pumps for sanitizers

Spray Bottle Percept to clean:

Less commonly used Door Handles in areas where it can dry

Less commonly used Railings in areas where it can dry

Sink taps in rest rooms

Toilets, floors and walls rest rooms

Housekeeping equipment

Linen carts and Buckets

Cleaning/disinfecting done by Nursing

Accel wipes will be needed to clean:

Thermometers

BP cuff

SPO2

Stethoscopes

Phones and RN cell phones

Keys

Computer keyboards and mouse

Pens

Name tags

Top of med cart

Spray Bottle Percept to clean:

Desks (tops and sides)

Equipment that can sit for 5 minutes and is not needed right away

Sides, back and handles of med carts

Care carts

Tub Chairs

Shower Chairs

Cleaning Routines and Duties

Cleaning routines and duties will vary depending on the area to be cleaned and the circumstances which are occurring. Additional cleaning practices that go beyond those routinely required are put into place when there is a known or suspected infection/colonization or outbreak.

<u>Front Entrance Do twice per shift</u>

Wipe ALL High touch surfaces with Accel wipes and or percept-including but not limited to-touchpads, door handles, railings, phones, keyboards, remotes for TVs, etc.

Wipe coffee shop tables – edges / legs, chairs.

Wipe end tables and ALL other surfaces-Arms on chairs

Wipe all high touch surfaces to Daycare

Wipe all elevator area – vacuum carpets and clean under carpets

Clean, wash all high touch surfaces in both men's and woman's restroom

Stairwells-Home Area 1-4 done twice per shift

Wipe hand rails in stairwells from top to bottom- should be completed once in morning and again in afternoon

Elevators-Home Areas 1-4 done twice per shift

Wipe hand rails/ buttons from top to bottom inside and outside elevators- should be completed once in morning and again in afternoon

Plaza #3-Link to Jasper, mezzanine sitting area, rest room, hall to link, link Do twice per shift

Wipe hand rails from top to bottom- should be completed once in morning and again in afternoon

Plazas- Outside Units

Classroom: Wipe tables, dust windowsills

Board Room: Wipe tables, dust windowsills.

Resident Laundry Room: Wipe ALL High touch surfaces with ACCEl Wipes

Hallway to Laundry

Wipe ALL High touch surfaces with ACCEl Wipes

Wash floor

Wash floor in Laundry area

Locker rooms/Restrooms/Staff Lunch Room/Back Entrance/Loading Dock/Staff Entrance

Wipe ALL High touch surfaces with ACCEl Wipes

Clean, sweep and wash both washrooms (men's / ladies)

Sweep and wash floor in sitting room and change rooms

Wipe down Lockers

Clean all toilet stalls and toilets

Wipe exit door handles and fob pad-4-5 times per shift

Wipe Screening table – edges / legs, chairs with percept spray

Wipe plexi glass

Wipe down heat radiator

Outside table drop off

Wipe entrance door handles and fob pad-4-5 times per shift

Wipe ALL High touch surfaces with ACCEl Wipes and or percept

Wipe tables – edges / legs

Wipe ALL other surfaces on any equipment or containers on tables

Auditorium

Wipe ALL High touch surfaces with ACCEl Wipes

Deep Cleaning on Home Areas:

Plaza #1, Week 1 and Week 3

Steam (as needed) and wipe down all furniture on home area #1, all chairs and sitting areas should be cleaned during this time.

Deep Clean Shower Room on left court- Diversol and power wash (done 2x per month)

Back stairwells– clean thoroughly

Deep Clean Shower Room on left court- Diversol and power wash (done 2x per month)

Wipe down/clean tables and chairs in dining room

Plaza #2, Week 2

Steam (as needed) and wipe down all furniture on home area #2, all chairs and sitting areas should be cleaned during this time.

Deep Clean Shower Room on left court- Diversol and power wash (done 2x per month)

Back stairwells– clean thoroughly

Wipe down/clean tables and chairs in dining room

Plaza #3, Week 3

Steam (as needed) and wipe down all furniture on home area #3, all chairs and sitting areas should be cleaned during this time.

Deep Clean Shower Room on left court- Diversol and power wash (done 2x per month)

Back stairwells– clean thoroughly

Wipe down/clean tables and chairs in dining room

Plaza #4, Week 4

Steam (as needed) and wipe down all furniture on home area #4, all chairs and sitting areas should be cleaned during this time.

Deep Clean Shower Room on left court- Diversol and power wash (done 2x per month)

Back stairwells– clean thoroughly

Wipe down/clean tables and chairs in dining room

NOTE: All cleaning tasks are subject to change based on the current needs of the home

Laundry Routine

For Resident Laundry and Home Laundry

Delivery of clean linen and clothing to rooms – Linen cart will be placed outside of each plaza daily to be delivered during dinner service. Staff on plaza will take cart and put laundry away.

Wipe and clean all high touch surfaces in room during this time.

Organize and clean wardrobes – ensure clothing is neat and tidy

Audit clear bags with dirty isolation gowns – take them to dirty utility to be take to wash

Take dirty linen to laundry room at end of shift to be washed.

Laundering Staff Uniform Process

Laundry Staff

Laundry staff will be made available to pick up uniforms daily between 3:15 and 3:30 pm. Laundry Staff will complete a 70 minute wash and dry cycle and then fold and return clothing back to designated area in locker rooms before 6:00pm on the same shift.

Green linen bags will be put into service and staff will use these as a marker that they are uniforms to be washed. Male and female uniforms will be washed together and delivered to same area, laundry staff will do their best to match up tops and bottoms.

Staff laundering program

Staff will be responsible to mark their own uniforms that they are leaving for wash.

Staff will be expected to place their uniform in clear plastic bags and place them into the green bags placed in their designated locker rooms.

Staff must understand that their clothing will be washed in our residential wash and should not be washed in our harsh wash, therefore there is still a risk their scrubs could be damaged depending on age and condition they are in.

Staff will also be advised to have a spare uniform in the event the laundry was not completed, and their uniforms are not ready for 7:00am.

Evening staff will not receive their clean uniforms until the day after if participating in this program, so must plan in advance.

Male and female uniforms will be washed together and delivered to same area, staff will have to sort their uniforms.

Appendix O: Situational Management and Risk Assessment

This risk assessment checklist should be completed at the onset of an outbreak to assist in managing the situation, identifying any early risks or deficits, and ensuring the best possible outcomes.

Please note: Ministry of Health and Long-Term Care (MOH, MOLTC) or Public Health (PH) direction to implement additional precautions or procedures will depend largely on the availability of resources (human, financial, etc.) and may be affected by the lack of same.

Checklist / Communication Plan **First day of suspected case or outbreak** **(yy/mm/dd):_____**	**Date *Initiated* yy/mm/dd**	**Initial when completed**
Main Entrance ☐ Outbreak signs are posted at front, staff and Jasper entrances ☐ Outbreak signs are posted on affected areas ☐ Alcohol based hand sanitizer (ABHR), surgical masks, tissues are available ☐ Screening in place at entrances ☐ If required by MOH / PH, active screening may be required		
Care area ☐ Residents are actively screened for symptoms ☐ Residents are monitored daily for respiratory / enteric symptoms and recorded on daily surveillance record and progress notes if symptomatic ☐ Residents with acute respiratory symptoms, fever or enteric symptoms are immediately isolated and precautions implemented ☐ If required by MOH / PH, daily temperatures may be required		

Upon declaring probable or confirmed respiratory or COVID-19
☐ Isolate the resident(s) – preferably in a private room with door closed
☐ Consider implementing Sick Bay policy if multiple residents/outbreak
☐ Place a mask on residents if transferring within the home
☐ Place appropriate signage (droplet contact precautions) outside of room
  ☐ If resident has a CPAP, Tracheostomy or requires suctioning or CPR, then Airborne precautions are required and a private room is preferable
  ☐ Place PPE equipment inside door of room, including ABHR		

☐ Place donning and doffing signage outside of room ☐ PPE must be worn before entering room ☐ Assess resident and call physician, confirm if sending to hospital or staying in LTC. Twice daily temps, O2 sats, pulse at minimum. ☐ If testing is required (NP swab), registered staff completing the testing must follow Airborne precautions and use an N95 mask during the procedure ☐ All staff providing personal care / coming within 2m of the resident must follow droplet contact precautions ☐ Follow PH or MOH direction regarding isolation of roommates / care areas ☐ Follow PH or MOH direction regarding the cohorting of staff either to symptomatic resident or to care area ☐ In room tray service for isolated residents ☐ Environmental Cleaning – follows droplet contact precautions ☐ Implement enhanced cleaning protocols ☐ Visitors are limited to essential visits only, must follow droplet contact precautions and wear PPE		
☐ **Upon declaring probable or confirmed enteric** ☐ Isolate the resident(s) – preferably in a private room with single bathroom ☐ Place appropriate signage (contact precautions) outside of room ☐ Place PPE equipment inside door of room, including ABHR ☐ Place donning and doffing signage outside of room ☐ PPE must be worn before entering room ☐ Assess resident and call physician ☐ If testing is required, staff must wear appropriate PPE when obtaining specimen ☐ All staff providing personal care must follow contact precautions ☐ Follow PH or MOH direction regarding isolation of roommates / care areas ☐ Follow PH or MOH direction regarding the cohorting of staff either to symptomatic resident or to care area ☐ In room tray service for isolated residents ☐ Environmental Cleaning – follows contact precautions ☐ Implement enhanced cleaning protocols ☐ Visitors are limited to essential visits only, must follow contact precautions and wear PPE		
Upon declaring an outbreak, notify the following members of the home IPAC team (Please note, not in any order of importance) ☐ Director of Care, lead of IPAC ☐ Administrator ☐ Homes Outbreak Mgmt team		

☐ Medical Director / Family Physicians/NP ☐ Medical Officer of Health (if applicable) ☐ Local Health Unit ☐ Director of MOHLTC by initiating a CIS form ☐ Ministry of Labour (MOL) if applicable ☐ The Union(s) representative ☐ Pharmacy provider ☐ Any community partners which may visit or deliver to the home ☐ Community placement coordinator (LHIN) ☐ Local hospital emergency department / paramedics ☐ Nursing agencies ☐ Residents/families/SDM ☐ Volunteers ☐ Hairdresser ☐ Community schools / students ☐ Coroner's office (follow procedure) ☐ Patient Transfer Authorization Centre		
In any outbreak situation ☐ Follow directions as mandated or directed by MOH, MOLTC or PH for most up-to-date requirements ☐ Initiate line listings – separate listings for Residents and Staff! Follow process for updates and notification to local PHU ☐ Ongoing monitoring of staff and essential visitors may be required, including temperatures and active screening ☐ For COVID-19 outbreak, consider referring to COVID-19: Infection Prevention and Control Checklist for LTC and Retirement Homes ☐ Ensure appropriate supplies are available and accessible for staff ☐ Ensure plan is in place for timely ordering of additional supplies and PPE as required ☐ Plan for regular Outbreak Mgmt Team meetings for regular status updates and decision making related to outbreak ☐ Review and implement staff cohorting as required ☐ Dedicate equipment to ill residents where possible ☐ Review and increase (where possible) environmental cleaning ☐ Cancel social / communal activities • Reschedule non-urgent appointments ☐ Make educational resources / teaching available regardin ☐ Reschedule non-urgent appointments ☐ Make educational resources / teaching available regarding infection control, hand hygiene, PPE ☐ Review and restrict (where required or directed) visitors to the facility ☐ Outbreak Mgmt Team should consider implementing the Pandemic plan and/or Sick Bay protocol as required		

Organizational IPAC Risk Assessment

An IPAC organizational risk assessment can help provide a framework for the IPAC components of an outbreak plan. The risk assessment can help an organization identify areas of strength, weakness, threat and opportunities for improvement to mitigate risks. Below is a list of IPAC elements to consider.

1.	**Infection Control Program**	**YES**	**NO**
1.1	Is there a person(s) responsible for IPAC?		
1.2	Is there a multi-disciplinary team responsible for outbreak management?		
1.3	Do those responsible for IPAC have support (i.e., resources [e.g., time, funding], senior leadership) to carry out necessary activities?		
1.4	Do you have established IPAC policies and procedures?		
Comments			
2.	**Education**		
2.1	Are HCWs, staff, students and volunteers educated with respect to IPAC processes and strategies (e.g., hand hygiene, point-of-care risk assessment, Routine Practices, Additional Precautions, donning and doffing of PPE, Healthy Workplace policy, cleaning/disinfection of resident care equipment)?		
2.2	Does this education occur at orientation and on a continuing basis?		
2.3	Are residents educated with respect to hand hygiene?		
Comments	** The PHO Infection Prevention and Control Fundamentals document provides a list of educational resources		
3.	**Hand Hygiene**		
3.1	Is hand hygiene, supported with ABHR, available at point-of-care and in other resident and common areas?		
3.2	Are hand hygiene sinks available in all resident care areas?		

3.3	Are hand hygiene supplies maintained/replenished when needed?		
3.4	Are audits of hand hygiene compliance performed?		
3.5	Are reminders to perform hand hygiene and ABHR available for visitors to the home / in common areas?		
Comments	****Obtain and review Hand Hygiene audits**		
4.	**Personal Protective Equipment & Supplies**		
4.1	Is PPE readily accessible to HCWs, including N95 respirators, if facility has AGMP?		
4.2	Are HCWs and staff educated with respect to which PPE should be worn when providing care for a resident on Droplet/Contact precautions		
4.3	Are HCWs and staff educated on how to safely don and doff the PPE?		
4.4	Does the home have signage on hand and ready to go regarding outbreaks, screening measures, closures etc.?		
4.5	Does the home maintain an adequate supply of PPE for resident care? Does the home maintain a back-up supply of PPE for outbreaks or emergencies?		
Comments			
5.	**Surveillance**		
5.1	Do you have a surveillance program in place (e.g., surveillance for acute respiratory infections and gastroenteritis)?		
5.2	Have the HCWs received education and training on their role in the surveillance program?		

5.3	If a resident presents with symptoms of COVID-19 or other respiratory illness, do staff know to immediately implement Droplet/Contact precautions?		
5.4	If a resident presents with symptoms of gastroenteritis illness, do staff know to immediately implement Contact precautions?		
5.5	Does the organization connect with the local PHU regarding surveillance? Consider: How does your internal IPAC lead/team interact with external bodies and authorities (e.g., Public Health Ontario, local PHU, etc.)?		
5.6	Who is the organization's PHU liaison? Do you have their contact information?		
5.7	Who will have input and approve your plans?		
Comments	**The Ministry of Health's Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018 can provide guidance on surveillance. ****Obtain and review infection control statistics and trends**		
6.	**Testing**		
6.1	Does the home have a process in place for ordering tests kits/requisitions?		
6.2	Does the home have a supply of test kits for respiratory illness on hand?		
6.3	Does the home have a supply of test kits for enteric illness on hand?		
6.4	Is there a policy and procedure on nasopharyngeal (NP) swab collection?		
6.5	Have HCWs been educated and trained on NP swab collection?		
Comments			
7.	**Environmental Cleaning**		

7.1	Are there policies and procedures regarding staffing in Environmental Services to allow for surge capacity (e.g., additional staff, supervision, supplies and equipment)?		
7.2	Have the Environmental Services (ES) staff received education and training on the correct way to clean (e.g., use the correct dilution, correct contact time, clean from clean to contaminated and from top to bottom, do not double dip)?		
7.3	Is there a policy and procedure for cleaning rooms of residents who are on Droplet/Contact precautions (suspect and confirmed cases)?		
7.4	Is the home using a health care grade cleaner/disinfectant with a drug identification number (DIN)?		
7.5	Is equipment that cannot be dedicated to a single resident cleaned and disinfected between residents?		
7.6	Have the HCWs received education and training on the correct way to clean equipment that is used on multiple residents (e.g., use the correct dilution, correct contact time, clean from clean to contaminated and from top to bottom, do not double dip)?		
7.7	Are high-touch surfaces cleaned at least twice per day? Is there is a list of the high-touch surfaces, who is cleaning them and when? Is this information recorded daily?		
Comments			
8.	**Communication**		
8.1	Does your home have an outbreak management communication protocol to connect with families and residents, other facilities in your area and/or the media?		
8.2	Does your home have a process for transfers that includes notification about a resident's suspected or confirmed diagnosis (e.g., presence of respiratory or enteric symptoms or known COVID-19) prior to transfer?		
Comments			
9.	**Building Design – Provision of Care**		

9.1	Does the design/infrastructure of your LTCH facilitate infection control practices, such as cohorting?		
9.2	Is the home primarily single rooms or do you have multiple semiprivate or ward rooms?		
9.3	Does the home have the ability to place a single resident on Additional Precautions (e.g., Droplet/Contact precautions) that require a single room?		
9.4	Does the home have negative pressure rooms?		
9.5	Have alternative outbreak plans been considered to support IPAC measures, such as: • Rooms to provide additional accommodations / cohorting of staff (breaks and lunches) • Sick Bay		
Comments			
10.	**Human Resources**		
10.1	Does the home have sufficient human resources for the provision of nursing care and support services (e.g., environmental cleaning and dietary services)?		
10.2	Has a contingency plan with respect to human resources been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities and essential facility operations?		
10.3	Would it be possible to re-deploy some human resources in an outbreak?		
Comments			

Individual Copies of the Situational Management Checklist and IPAC Risk Assessment can be found on the home's shared drive – Pandemic Folder – 2022 IPAC Files – IPAC ERP 2022

Appendix P: Staff Cohorting Plan

In the event of an outbreak and/or enactment of the IPAC emergency response plan, the staff cohorting plan will be initiated.

All staff will be expected to work in dedicated and assigned areas of the home to reduce risk of transmission of the illness of concern within the home, between staff and residents.

Each home area has the capacity of limiting staff from movement due to the design, with each having access to an employee washroom and kitchenette.

The living room on the left court of each home area will be converted into a temporary staff break room that can accommodate those working in each area and minimize movement during breaks.

Each person working in a resident home area will be expected to remain in that area for their shift. Movement will be limited within the entire facility, between home areas and departments. The following plans will be in place for each department/worker.

Any scheduled in person meetings will be cancelled. Any urgent, required meetings will be scheduled virtually or by phone.

Outbreak signage will be placed on the closed doors of the affected home area, as well as facility entrances.

Anyone working on, or going onto, the affected home area will be expected to wear appropriate PPE as instructed by signage prior to entering the home area. PPE will be placed outside each home area affected in the event of an infection prevention and control emergency requiring implementation of this plan. PPE required may consist of the following: medical mask/or N95, eye protection, gloves and gowns at all times while on the unit.

Departmental Guidelines

Nutrition & Food Services:

- FSWs working on floors start the day in the Main Kitchen completing assigned duties before going to their floor.
- FSW shifts cohorted to their floor for the remainder of the day; return carts to Main Kitchen at the end of their shift using the service elevator.
- Staff meals for cohorted staff delivered to each floor to help reduce outside exposure including staff leaving/returning for meals.
- Portering shift added to deliver food/supplies to staff cohorted to floors.
- Kitchen staff stay in their areas for the day.
- Staff breaks may be taken in the cafeteria for those working in the kitchens, and FSWs are to stay in the resident home areas for breaks.

Environmental Services

<u>Housekeeping</u>

All housekeeping staff are to enter the home unit and remain on until the end of shift, unless they are exiting for break or smoke to exterior of facility.

During cohorting housekeeping staff will submit their supply list via email to the Environmental Services Supervisor. The unit computer can be used and home area email address as source to send their request.

If anything off unit is needed during the day housekeeping staff will contact laundry staff to meet them for linen supplies and clear BM bags (NOT CLEANING) and to exchange carts. Laundry will be responsible to wash all wash bins and carts before going back into units.

Curtains and drapery will need to be given to laundry staff in clear marked bag, once it is washed a pickup time will be coordinated with the housekeeping staff on the unit to ensure these items make it back to the proper place.

If maintenance is on unit, they can be available to help as needed.

Communication between Laundry and Housekeeping should be consistent through out the day and with the extra shift as housekeeping staff will not be able to leave the unit and may need laundry staff to assist in some capacity.

Possible overflow of clothing can be placed in a clean bucket and stored in the clean side until next day delivery.

Laundry Services

Laundry Staff are to remain in laundry area for most of the shift, except for breaks and laundry pick up times listed below:

10:45am (P1/P2) 11:00am(P3/P4) Garbage and Linen Trade- Dirty linen will be picked up by housekeeping staff and brought to unit doors where laundry Staff will be waiting for pick up and drop off of the clean laundry bins that were washed in the am after soiled linen wash. Housekeeping will also grab dirty clothing protectors for wash at this time to give to laundry.

11:30am- Laundry staff will return wash buckets sanitized to outside of unit for pick up by housekeeping staff.

3:00pm- End of shift housekeeping staff will take out mop heads and rags at end of shift for laundering-until further notice if separate entrance comes into play, this will change.

10:00pm- End of shift take out soiled linen bins and leave in soiled linen area, take clean cart, and make arrangements with nursing staff to pick up at plaza entrance.

If laundry staff are to work on units in housekeeping, they are not to go from floor to floor unless there is a full 24-hour period between these shifts. Staff are permitted to work on a unit and return the next day to laundry room in clean uniform with PPE. Laundry staff are able to smoke at designated smoking area and take breaks in the café or lunchroom.

Maintenance Services

Maintenance will be cohorted with 1 F/T covering Plaza 3 and 4, One F/T covering 1 and 2 and one F/T covering front of house and grounds. Maintenance student will strictly be outside grounds unless absolutely necessary or inclement weather.

If outbreak occurs on one home area, maintenance memos and routines will be scheduled that so that they are completed at the same time closer to the end of a shift, so there is no crossing over to other home areas.

If a worker is working alone and non-urgent work orders come from the unit in outbreak, they will be completed towards the end of the shift.

Staff will have to prioritize maintenance memos as they have been trained to do.

Therapeutic Recreation

Therapeutic Recreation employees will be assigned to continue to work on their assigned care areas. In the event additional staff are working, they may be assigned to the outbreak area as long as they remain assigned to this area for the remainder of their shifts.

Therapeutic Rec. to inform or cancel the following: volunteers, Hospice Northwest/entertainment, outings/transportation, maintenance set ups for auditorium or other areas, dietary requisitions for auditorium programs, contractors (fish tank).

During summer months, garden volunteers will need other arrangements for bathroom facilities such as renting an outdoor “porta-potty”.

1 TR staff assigned to each home area; part time and casual staff cover on days when staff off-24 hours in between shifts, when working on different home areas, hire casual staff as required.

Each home area has their own individual program supplies and 1 T.R to pick up additional supplies for their activities from storage room in non-resident area, following all I.P.A.C measures, at start of their shift, prior to entering their home area, Supervisor will shop for monthly supplies.

If there are deployed staff: they will be assigned to a home area. Resident deliveries to each home area will be picked up from screening area at start of their shift, prior to the deployed worker going onto their designated home area.

Administration

Administrative staff will work in their dedicated workspaces. They may take their breaks in their workspaces or cafeteria. When there is an outbreak on a home area where staff offices are located, these people should remain on the home area and limit any movement unless necessary to address issues related to the management of the home.

Nursing

Direct care staff will be dedicated to work in one home area. The following guidelines apply to the nursing department:

- RN staff will direct and track any staff re-assignment shifts if staff are required to move from one care area to another during their shift.
- Any changes will be communicated to centralized scheduling and the clinical manager through daily attendance report.
- Staff caring positive (or suspected positive residents) will be dedicated to care for those residents only.
- Staff movement spreadsheet will be maintained by centralized scheduling to facilitate tracking and reporting of staff movements within the home.
- In the event staff must move between cohorts, they should only move from the lowest risk cohort to the highest risk cohort.
- During emergency procedures, movement within a shift will require that the employee’s uniform must be changed, all used PPE disposed of, and hand hygiene performed.
- Any employee, volunteer, agency staff, student deployed to a home area affected by an outbreak due to critical needs will be considered dedicated to that area until there are enough days between shifts to return to their previous assignment.

- The timeline for the movement from the affected outbreak area back to the non outbreak areas when staff are deployed to assist in addressing critical staffing issues will be determined by the disease of concern and public health recommendations.

Employees in all areas of the home may go outside for breaks, if they remain in their working cohorts and avoid close interactions with staff from other areas of the facility. Physical distancing will be practiced throughout the home, as well as any outdoors spaces with a minimum of 6 feet distance between staff from different cohorts.

Emergency Exemptions

Safety overrides cohorting of staff in emergency situations such as medical emergencies requiring additional assistance such as “Nurse One” or “Code White”. This also applies to other emergencies requiring staff to move onto other areas, such as in the “Code Red - Fire” or “Code Green – Evacuation” when directed to do so by the RN (PICC) or nursing managers.

Appendix Q: Staffing Contingency Plans

In order maintain staffing levels for the care of residents in the home, the staffing contingency plan will be implemented. There may be times where internal staff movement decisions will be made to address shortages in areas affected by outbreaks. This may mean a staff member from another home area will be deployed to an affected area. In this case, the person deployed will have to complete the remainder of their work shifts on their schedule on the affected area.

If internal staffing needs are not met due to critical staffing issues, additional resources may be required.

Screener Process

Screeners have an electronic record of all home staff, volunteers and agency staff. Cohort assignments (DSA - Daily Shift Assignment) for nursing staff are posted daily at the screening desk. Clinical managers/supervisors will provide any changes to cohorts to the screener.

Staff Rotations

A master rotation is kept current to reflect the consistent daily staffing needs for each job group including any relief staff. Daily shift assignments are used by the nursing department to track shortages and needs.

The current schedules are designed to ensure adequate staffing compliment to meet resident care needs and standards. In the event of an outbreak/pandemic planned rotations specific to cohorting and resident needs would be implemented.

- Centralized Scheduling is responsible for the design, change and maintenance of the master rotation based on requirements dictated by the clinical management leads from the homes.
- Pandemic Outbreak Relief (POR) rotations are created and implemented to reflect up staffing due to cohorting needs.
- Pandemic Outbreak Relief (POR) rotations will be built based on operations direction of required upstaffing needs. This will include positions and rotations built per home area while in a pandemic or an outbreak ensuring all shifts are assigned to specific home areas.
- Nursing management and Centralized Scheduling will collaborate to ensure home area requirements will be filled in priority order and by position.

Centralized Scheduling will then implement the POR rotations per unit and position and begin the filling process to cover these. Firstly, attempting to fill all rotations with Pioneer Ridge staff before moving to agency staff. Part-time Casual, external hiring and then agency staff will be utilized to fill rotations.

Staffing Contingency In order to meet staffing requirements of a home during an outbreak, needs may not be met with internal Pioneer Ridge employees alone and additional resources may be required. The following strategies will be undertaken to ensure adequate staffing levels as defined by the Home Nursing Management team are achieved:

Contingency Strategies

- Recruitment campaigns facilitated by PR & Human Resources with on going open postings for all nursing positions and pandemic support workers remains open to applicants.

- Recruitment of City of Thunder Bay other department workers that are able to be redeployed to the home.
- Reach out to local Hospitals & community agencies (LHIN, Ontario Health, Family Health Teams, Red Cross, etc.).
- Increase agency contracts.
- Engagement of contracted agency staff with signed contracts and all necessary documentation.

Failed screening Process: If an employee/visitor /anyone entering the home fails the screening tool, they are immediately given a mask, then the Manger or RN is called to assess. Assessment outcome will determine if the person will be asked to go home and self isolate, seek treatment, call the local health unit or COVID- 19 assessment centre. If they are a Pioneer Ridge employee, they may be tested at this time in a non-resident care area prior to leaving the home. (Loading dock area) Management and scheduling will be alerted to replace any impacted shifts. Director of Nursing will be alerted and will follow up with affected staff member.

Centralized Scheduling Process

The schedule of all rotations and positions is posted and can be seen via electronic schedule. All Pioneer Ridge scheduled employees, (nursing, maintenance, housekeeping, food services and therapeutic recreation) run on a 4-week advanced rotation schedule. Advanced shift booking call out is completed in descending seniority by centralized scheduling on a biweekly basis. During this process centralized scheduling, the manager and employee all have a role to play.

- Centralized scheduling lists shift needs for all 4-week nursing rotations.
- Therapeutic Recreation, Environmental services and Food Services 4-week rotations are scheduled through their supervisors and posted in their program areas.
- All empty shift needs are called out in order of descending seniority for Pioneer Ridge staff to pick up.
- Daily shift report is sent out to nursing management and appropriate supervisors at 1400 each day via email.
- Daily Shift Assignment reports are posted at the screening desk and hard copies sent to each home area and supervisor.
- Management /supervisors and scheduler will meet weekly to review unfilled shifts for the posted schedule to plan for relief needs and cohort planning.

Short Call Booking 0-7 days

Short call absences can occur daily. Centralized scheduling will endeavour to fill the shift by calling out in order of descending seniority as per staff assigned to the cohort area. Scheduling will then look to juggle and offer moves to overstaffed employees on different days/times or same day shifts at different times while ensuring cohorting to their assigned unit. If they exhaust staff in that cohort they will then look to fill with staff that have been out of the home for a period of 24 hours to ensure they have length of time between cohort moves. If relief is not found in the short call process, they may reassign employees across cohorts as per operational requirements. If unable to fill shift and home area is unable to cope with a staff shortage, contingency plan will come into affect. Scheduling will track all movement on the staffing spread sheet and schedule.

- Scheduler will identify short call shift and follow call out process.
- Scheduler will exhaust staffing options and report to management.
- Management will enact contingency plan.

- Scheduling will update employee spread sheet and schedule to reflect outcome of call out.

If relief is not found, the scheduler will communicate to the homes DON, Clinical Managers and RNs to review the unfilled shifts for shift filling strategies or cohort reassignment options. Where a shift filling option has been identified, the supervisor/RN will notify scheduling as soon as possible- will fill out daily attendance report for tracking purposes in RN communication/call in binder on Home area 3.

Reassignment of Cohort

During times of outbreaks/pandemics the Pioneer Ridge OMT along with centralized scheduling will, to the best of our ability, based on physical layout of the home and staffing levels, restricted staff to working on only ONE resident home area as much as possible.

Employees may be reassigned to a different cohort to create equitable staffing levels through out the home. Employees may be required to continue in there assigned shifts of their rotation but may be stationed in a different home area due to decreased staffing levels. This may happen for a specified period of time or until the end of the outbreak. Reassignment of cohort can also happen due to short call-in absence or employees leaving due to unforeseen circumstances. The daily assignment reports are delivered by centralized scheduling by 1400 each day into each supervisor's mailbox advising the next day staff assignment. Supervisors are then aware of the staff assigned to and working at each shift in each home area. (note FS, Enviro and TR do their own daily assignment)

- Employees may be assigned to a different cohort with the same rotation for a specific time period.
- Employees may be assigned to a different cohort within a 24 hour stay period between cohorts.
- Employees may be assigned to a different cohort with in the same 24 hours provided they change uniforms, perform appropriate hand hygiene and wear appropriate PPE.

Updated daily assignment reports are delivered to supervisors by 1400 each day. If staff move between cohorts at the beginning or anytime into a shift due to resident care needs, the RN will communicate this to home management noting the employee's name, original cohort assignment, cohort reassignment and the reason for the cohort reassignment. Scheduling will receive the Daily Attendance Report (DAR) from the night staff before 07:00 for the previous day and will update the scheduling system with any applicable changes.

Scheduling Process - Outbreak

In the event of a widespread outbreak/pandemic Pioneer Ridge's Pandemic Plan will form the basis for all outbreak pandemic planning. Control measures will be implemented as soon as possible to manage and reduce outbreak situations. The OMT will meet daily and with listed in house and community members. Included in the reporting will be the cohorting plan.

While in outbreak, daily the Centralized Scheduling will deliver to the DON a report that outlines the following staffing requirements:

- Baseline & upstaff requirements for 5 day forecast and 24-hour baseline forecast.
- The staffing list with names, shift times and cohort assignment.
- Number of Pioneer Ridge staff scheduled per position and cohort.
- Number of deployed staff scheduled per position and cohort.
- Number of agency staff scheduled per position and cohort.

- Previous day actuals.
- Agency updates including agencies contacted, contract status and if they have staff available or not.

Schedule Build Process Occurs monthly per the Schedule Build Process.

1. The scheduler will assign all employees to their home units' cohort only. This will mean that a unit's cohort may be short while another units' cohort is above their requested requirements. All efforts will be made to fill all shifts while adhering to the cohorting plan to prevent outbreak within the home at large.

2. The scheduler will assign all regularized relief staff, POR and Agency staff in all baseline/up-staffing requirements. Where an open shift is not available, the scheduler will assign the regularized relief, POR or Agency shifts to the employee home units' cohort.

3. Casual employees who do not have a unit cohort assignment will be assigned a home unit cohort for the duration of the outbreak.

4. The schedule build process is completed by centralized scheduling who will then act as outbreak schedulers in charge of maintaining the schedule for Pioneer Ridge.

5. Centralized scheduling will verify the schedule to ensure that all staff are on the appropriate home unit cohort assignment and will adjust as necessary

6. The schedule will be posted electronically as per Pioneer Ridge process

Scheduling Advanced Shifts biweekly to the end of the posted schedule

1. The scheduler will award open shifts to interested employees from each of the home areas cohort only.

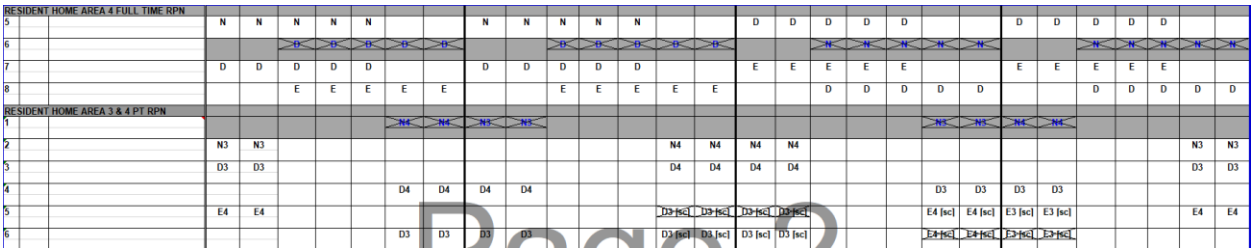
a. This may mean that a unit's cohort may be short while another unit's cohort is above their requested requirements (baseline and upstaffing requirements). All efforts will be made to fill all shifts while adhering to the cohorting plan to prevent outbreak within the home at large.

2. The scheduler will prioritize filling baseline shifts prior to filling open upstaffing requirements.

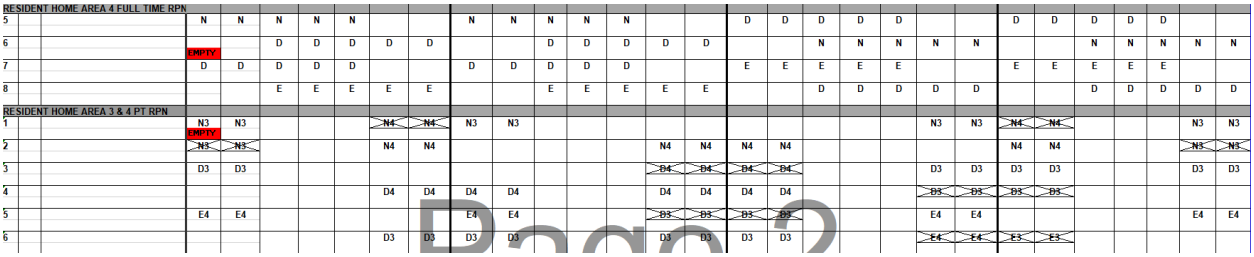
3. The scheduler Clinical Managers and Supervisors will meet weekly to review unfilled shifts for the posted schedule to plan for relief needs and cohort planning.

Excerpt of master rotations and Pandemic Outbreak rotations

Master Rotations:

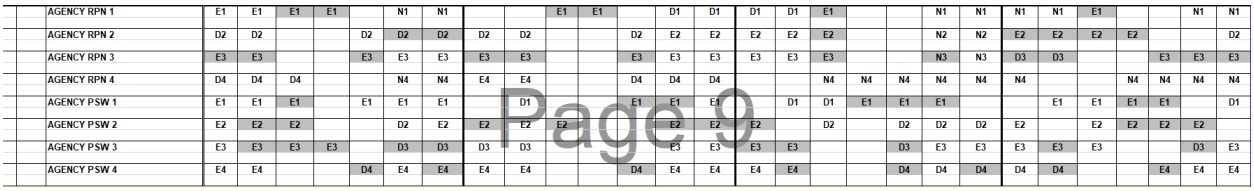


Pandemic Outbreak Rotations:



RESIDENT HOME AREA 4 FULL TIME RPN																													
5		N	N	N	N	N			N	N	N	N	N			D	D	D	D	D			D	D	D	D	D		
6		EMPTY		D	D	D	D	D			D	D	D	D	D			N	N	N	N	N			N	N	N	N	N
7		D	D	D	D	D			D	D	D	D	D			E	E	E	E	E			E	E	E	E	E		
8				E	E	E	E	E			E	E	E	E	E			D	D	D	D	D			D	D	D	D	D
RESIDENT HOME AREA 3 & 4 PT RPN																													
1		N3	N3				N4	N4	N3	N3												N3	N3	N4	N4			N3	N3
2		EMPTY N3	N3				N4	N4						N4	N4	N4	N4							N4	N4			N3	N3
3		D3	D3											D4	D4	D4	D4					D3	D3	D3	D3			D3	D3
4							D4	D4	D4	D4				D4	D4	D4	D4					D3	D3	D3	D3				
5		E4	E4						E4	E4				D3	D3	D3	D3					E4	E4					E4	E4
6							D3	D3	D3	D3				D3	D3	D3	D3					E4	E4	E3	E3				

Agency Staff Rotations:



AGENCY RPN 1	E1	E1	E1	E1		N1	N1			E1	E1		D1	D1	D1	D1	E1			N1	N1	N1	N1	E1			N1	N1
AGENCY RPN 2	D2	D2			D2	D2	D2	D2	D2			D2	E2	E2	E2	E2	E2			N2	N2	E2	E2	E2	E2			D2	
AGENCY RPN 3	E3	E3			E3	E3	E3	E3	E3			E3	E3	E3	E3	E3	E3			N3	N3	D3	D3			E3	E3	E3	
AGENCY RPN 4	D4	D4	D4			N4	N4	E4	E4			D4	D4	D4			N4	N4	N4	N4	N4	N4			N4	N4	N4	N4	
AGENCY PSW 1	E1	E1	E1		E1	E1	E1		D1			E1	E1	E1		D1	D1	E1	E1	E1			E1	E1	E1	E1		D1	
AGENCY PSW 2	E2	E2	E2			D2	E2	E2	E2	E2			E2	E2	E2		D2		D2	D2	D2	E2		E2	E2	E2	E2		
AGENCY PSW 3	E3	E3	E3	E3		D3	D3	D3	D3				E3	E3	E3	E3			D3	E3	E3	E3	E3	E3			D3	E3	
AGENCY PSW 4	E4	E4			D4	E4	E4	E4	E4			D4	E4	E4	E4	E4			D4	D4	D4	D4	D4			E4	E4	E4	

Initial Screening Tool

*Please note: the tool below may be modified to meet the screening requirements based on the disease of concern. This tool may be available in electronic format from CIT (used in 2020 pandemic).

Staff & Essential Visitors Screening Tool

Please ask ALL questions and then **forward this sheet to the Business Office.**

Screener_____ Date_____ Time_____
Employee/Visitor name_____Phone number _____
Reason for entering building (Department)? _____

Screening Questions

1. Do you have a fever? (take temperature; fever is a temperature of 37.8ºC or greater) ☐Yes ☐No

2. Do you have any of the following symptoms or signs?

New or worsening cough ☐Yes ☐No Shortness of breath ☐Yes ☐No Sore throat ☐Yes ☐No Runny nose or sneezing ☐Yes ☐No Nasal congestion ☐Yes ☐No Hoarse voice	☐Yes ☐No Difficulty swallowing ☐Yes ☐No New smell or taste disorder(s) ☐Yes ☐No Nausea/vomiting, diarrhea, abdominal pain ☐Yes ☐No Unexplained fatigue/malaise ☐Yes ☐No Chills ☐Yes ☐No Headache ☐Yes ☐No

3. Have you travelled or had close contact with anyone that has travelled outside of Canada in the past 14 days?
   □Yes □No
4. Have your travelled outside of Northwestern Ontario in the last 14 days? □ Yes □ No

5. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?
   □Yes – **go to question 6** □No – **screening complete**

---

6. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures (AGMPs)) when you had close contact with a suspected or confirmed case of COVID-19?
   □Yes □No

7. Attestation of negative COVID-19 test:
   I attest to Pioneer Ridge screening staff that I have tested negative for COVID-19 within the last 2 weeks of today's date and subsequently not tested positive.

DATE OF TESTING (Visitor): _____ signature _____

Results of Screening Questions:

• If the individual answers **NO to all questions from 1 through 4**, they have passed and can enter the home. They should be told to self-monitor for symptoms and be reminded about required re-screening at the end of their day/shift or when they leave the home.

• If the individual answers **YES to any question from 1 through 3,** they have not passed and **cannot** enter the home. They should go home to self-isolate immediately. Staff should contact their manager/immediate supervisor. Essential visitors should be told to contact a primary care provider, local public health unit or Telehealth to discuss their symptoms and/or exposure and seek testing.

• If the individual answers **YES to question 4 and YES to question 5,** they have passed and can enter the home. They should be told to self-monitor for symptoms and be reminded about required re-screening at the end of their day/shift or when they leave the home.

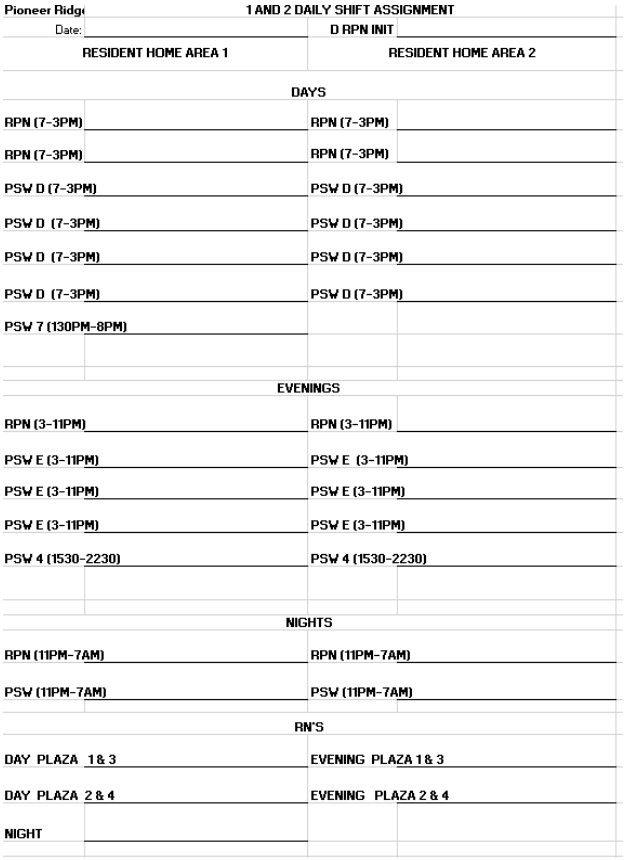
• If the individual answers **YES to question 4 and NO to question 5,** they have not passed and **cannot** enter the home. They should go home to self-isolate immediately. Staff should contact their manager/immediate supervisor. Essential visitors should be told to contact a primary care provider, local public health unit or Telehealth to discuss their symptoms and/or exposure and seek testing.

Based on the answers and the above criteria, the person screened today has:

□FAILLED THE SCREENING – **NOT allowed to enter the building (RN or Management called)**

□PASSED THE SCREENING – **was allowed to enter the building**

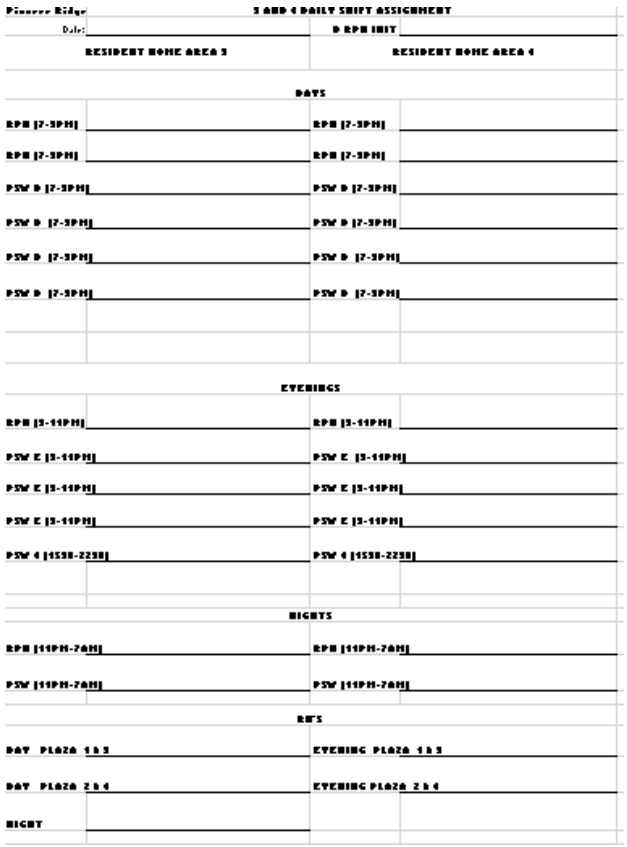
Daily Shift Assignment



Pioneer Ridge 1 AND 2 DAILY SHIFT ASSIGNMENT

Date: _____ D RPN INIT _____

RESIDENT HOME AREA 1	RESIDENT HOME AREA 2
DAYS	
RPN (7-3PM)	RPN (7-3PM)
RPN (7-3PM)	RPN (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW 7 (130PM-8PM)	
EVENINGS	
RPN (3-11PM)	RPN (3-11PM)
PSW E (3-11PM)	PSW E (3-11PM)
PSW E (3-11PM)	PSW E (3-11PM)
PSW E (3-11PM)	PSW E (3-11PM)
PSW 4 (1530-2230)	PSW 4 (1530-2230)
NIGHTS	
RPN (11PM-7AM)	RPN (11PM-7AM)
PSW (11PM-7AM)	PSW (11PM-7AM)
RN'S	
DAY PLAZA 1& 3	EVENING PLAZA 1& 3
DAY PLAZA 2& 4	EVENING PLAZA 2& 4
NIGHT	

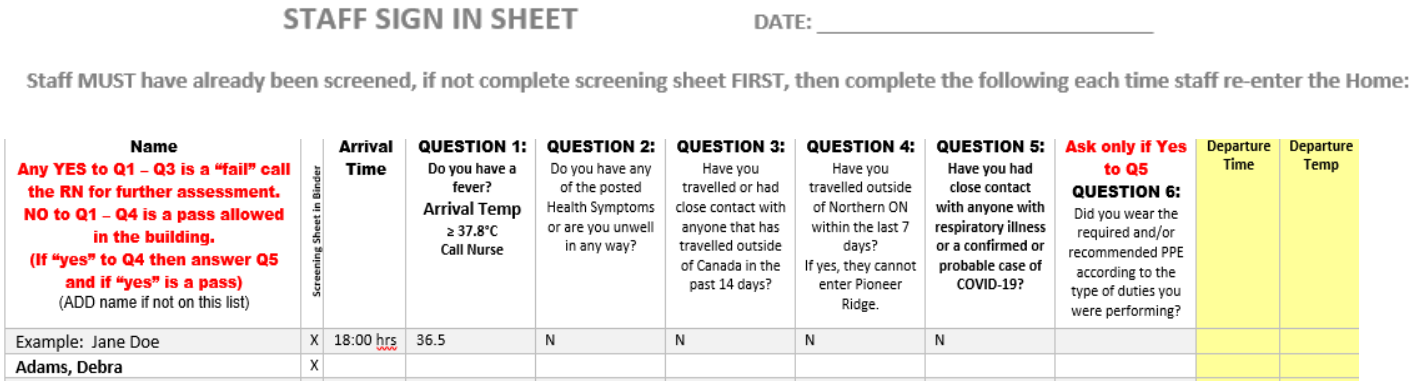


Pioneer Ridge 3 AND 4 DAILY SHIFT ASSIGNMENT

Date: _____ D RPN INIT _____

RESIDENT HOME AREA 3	RESIDENT HOME AREA 4
DAYS	
RPN (7-3PM)	RPN (7-3PM)
RPN (7-3PM)	RPN (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
PSW D (7-3PM)	PSW D (7-3PM)
EVENINGS	
RPN (3-11PM)	RPN (3-11PM)
PSW E (3-11PM)	PSW E (3-11PM)
PSW E (3-11PM)	PSW E (3-11PM)
PSW E (3-11PM)	PSW E (3-11PM)
PSW 4 (1530-2230)	PSW 4 (1530-2230)
NIGHTS	
RPN (11PM-7AM)	RPN (11PM-7AM)
PSW (11PM-7AM)	PSW (11PM-7AM)
RN'S	
DAY PLAZA 1& 3	EVENING PLAZA 1& 3
DAY PLAZA 2& 4	EVENING PLAZA 2& 4
NIGHT	

Screener Master List



STAFF SIGN IN SHEET DATE: _____

Staff MUST have already been screened, if not complete screening sheet FIRST, then complete the following each time staff re-enter the Home:

Name Any YES to Q1 – Q3 is a "fail" call the RN for further assessment. NO to Q1 – Q4 is a pass allowed in the building. (If "yes" to Q4 then answer Q5 and if "yes" is a pass) (ADD name if not on this list)	Screening Sheet in Binder	**Arrival Time**	**QUESTION 1:** Do you have a fever? Arrival Temp ≥ 37.8°C Call Nurse	**QUESTION 2:** Do you have any of the posted Health Symptoms or are you unwell in any way?	**QUESTION 3:** Have you travelled or had close contact with anyone that has travelled outside of Canada in the past 14 days?	**QUESTION 4:** Have you travelled outside of Northern ON within the last 7 days? If yes, they cannot enter Pioneer Ridge.	**QUESTION 5:** Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?	**Ask only if Yes to Q5 QUESTION 6:** Did you wear the required and/or recommended PPE according to the type of duties you were performing?	Departure Time	Departure Temp
Example: Jane Doe	X	18:00 hrs	36.5	N	N	N	N			
Adams, Debra	X									

Contingency Plan for Working Short Nursing Department

REGISTERED NURSES To meet MOH LTC Act & Regulations a nursing staffing contingency plan would be as follows. AN RN is required to be always in the building. If no RN is available call out as follows: BPC, CNM's, DON and Administrator. Call out for staff shortage includes qualified PSW staff from other departments listed on the call out sheets. (Employees cannot be pulled off their regular department shift). Call out is always in the order of seniority and if no scheduler is available the responsibility for replacing defaults to the RN.

After all attempts have been made to replace the vacant shift(s) in accordance with both the ONA and UNIFOR collective agreements and CTB policy; the following plan will be put in place.

It is an expectation that staff will prioritize duties and do their best to complete all duties.
1 RN in building

- carry both cell phones & respond to the needs of all clinical areas.
- Prioritizes and delegate to appropriate staff at the beginning and throughout shift as required.
- Coordinate ongoing care, including complex care needs through consultations with physicians,
- NP, resident, families and other member of the multidisciplinary care team
- Contact on-call CNM/DON for continued support

Shift Times	Classification & Full Compliment	Step 1	Step2	Step3	Step4
	RN's	Short 1 RN			No RN's available
Days 0700-1500	2 RN's in building. Each responsible for 2 home areas.	Call out- at regular time.	Call DON for OT approval prior to call out for 2nd RN (OT called for Doctors day)	1 RN responsible for all 4 home areas.	Call out to BPC, CNM, DON
Evenings 1500-2300	2 RN's in building. Each responsible for 2 home areas.	Call out- at regular time	Call DON for OT approval prior to call out for 2nd RN	1 RN responsible for all 4 home areas.	Call out to BPC, CNM, DON
Nights 2300-0700	1 RN in building. 1 RN responsible for 4 home areas.	Call out- at regular time, OTx1, OTx2 up to max OT.	Call out for BPC, CNM or DON.	Call in day RPN to come in for 0600 with meds to help if required	Must have RN in the building – Call out to Manager on call BPC, CNM or DON

If there is no RN available, call BPC (if not already done), CNM'S or DON then Administrator.

REGISTERED PRACTICAL NURSES

The RN may reassign scheduled RPN's to different home areas as deemed necessary. FIRST STEP: RPN initiative will be re-assigned to vacant unit before OT time is called and will communicate with RAI coordinator change in assignment – if there is no initiative then plan is as follows:

Shift Times	Classification & Full Compliment	Step 1	Step2	Step3	Step4
	RPN's	**Short 1 RPN**	**Short – no RPN's available for a home area**	**No RPN's able to be reassigned**	
Days 0700-1500	**2 RPN's per home area – each responsible for 1 court. Total 8 RPN's in building.**	**Call out at regular time, call OTx1, OTx2. Call through RN list.** **Work with 1 RPN on floor/RN will help as required**	**1 RPN may be reassigned from another home area leaving one RPN each home area. On days ensure that all home areas have a least one RPN and RN will help as required.**	**1 RN takes RPN roll on home area that is short and other RN takes whole building. Remaining RPNs in building will help out as required**	**Call extra help if required from BPC, NCM or DON.**
Evenings 1500-2300	**2 RPNs for each home area. Total 8 RPN's in building.**	**Call out at regular time. 1 RPN will do meds on the unit if unable to fill shift.**	**Call OTx1, OTx2. Call through RN list. Pull RPN from another home area.**	**1 RN takes RPN role on home area that is short and other RN takes whole building.**	**Call for direction from Manager on call.**
Nights 2300-0700	**1 RPN responsible for 1 home area. Total 4 RPN's in building.**	**Call out- at regular time, call OTx1, OTx2 up to max OT. Call extra PSW for floor coverage. If not available call through RN list**	**1 RN takes RPN roll on home area that is short for meds and spends majority of time on that home area.**	**Call in day RPN to come in for 0600 to help with meds if required**	**Call for direction from Manager on call.**

PERSONAL SUPPORT WORKERS

Resident care work board will be divided between the numbers of staff remaining on the unit that is short.

RPN initiative will float assisting the unit staff and perform PSW duties as necessary.

*HOME AREA 1 SHOULD NOT WORK SHORT

It is an expectation that staff will prioritize duties and do their best to complete all duties.

Breaks may need to be re-scheduled (not missed) to accommodate resident care.

PSWs and members of the interdisciplinary team (NUSW; RCW; TR; RAI coordinator; RNs; RC; NCM; DON; DA; HSK) are expected to work together on the units for dining room assistance and portering residents.
Pandemic relief workers will also be called to help with areas of portering, assisting with meals, nutrition snack times, friendly visiting, and virtual visits.

RN is responsible to assess the needs of the home and deploy staff throughout the building as necessary to ensure resident care needs are met. RPN also had team lead responsibility to monitor and ensure care needs of floor are met.
To cover PSW's calling in:

Shift Times	Classification & Full Compliment	Step 1	Step2	Step3	Step4
	PSW's				
Days 0700-1500 – 4 PSW's	5 PSWs on home area 1 4 PSW's on home areas 2,3 & 4 Total 17 PSWs in building.	For call in: call out for PSW at regular time.	Call PSW at OT x1 & OTx2. Call through to RPN's that will work as PSWs.	Have one RPN help on the floor and the other do the required RPN role for both courts with RN help.	Have initiative help where possible. Call through RN list.
Evenings 1500-2300 – 3 PSW's 1530-2230 – 1 PSW	4 PSWs per home area. Total 16 PSWs in building.	For call in: call out at regular time.	Call PSW at OT x1 & OTx2. Call through to RPN's that will work as PSWs. Call through RN list.	RN can help on the floor for times of need	RN can redeploy staff if necessary. For the times needed. Using appropriate judgement.
Nights 2300-0700 1PSW	1 PSW responsible for 1 home area. Total 4 PSWs in building.	Call out- at regular time, call OTx1, OTx2 up to max OT.	Call out for RPN to work floor at regular time. Call through RN list.	RN would need to assist on that home area	Call for direction from Manager on call.

Daily Attendance Report (DAR)

Pioneer Ridge Daily Attendance Report

Employee Absent	Date, Time and Reason of Call-In	Date Shift will be Absent	Home Area and Shift Staff was Scheduled	Employee Replacing Shift	Please indicate if when calling in or pulling a staff if a staffs designated Home Area was reassigned and why	Overtime Hours Used	Replacment Completed By:

Therapeutic Recreation

Environmental Services

Maintenance operations 7 days per week, staffing quota as follows for Maintenance

Monday	**2@F/T**
Tuesday	**3@F/T**
Wednesday	**3@F/T**
Thursday	**3@F/T**
Friday	**2@F/T**
Saturday	**1@F/T**
Sunday	**1@F/T**

Nutrition and Food Services

Scheduling:

Master rotations:

- 4 FT FSWs cohorted to one floor each.
- 5th FT FSW assigned to a different cohort with a 24 hour stay period between cohorts.
- Each PT FSW rotation cohorted to one or two floors; assigned to a different cohort with a 24 hour stay period between cohorts.
- Short call booking (0-7 days): floor assignments adjusted to allow for cohorting to one floor as possible.
- CS, MOW FSWs may be assigned to a cohort after completing the CS/MOW shift within the same 24 hours.
- Employees **are not** assigned to a different cohort within the same 24 hours; assignments adjusted as needed.
- All cook rotations and pot washer cohorted to Main Kitchen.
- Storekeeper cohorted to Main kitchen and Central Stores; Supplies from Central Stores dropped at entrance of Home Area.
- Assigned backup person for placing food orders or picking up supplies in the event the Storekeeper, Nutrition Manager is unavailable.

Schedules posted in department and available in E: Food Service/Scheduling

Reduced staffing:

- In the event FSW staff are reduced to 60% due to illness, staffing for resident meals takes priority; meal service for ancillary programs adjusted by utilizing available staff from other departments (i.e. Meals on Wheels) or Nutrition Manager, Supervisor or RD
- In the event cooking staff is reduced to 50% due to illness, 7-day emergency menu initiated for all meal service

Appendix R: Supply Management Plan

During an emergency, it will be important to ensure that there is a plan in place to minimize the risk of supply issues due to the increase in demands.

The home has an existing plan to have 2-week emergency stock of personal protective equipment (PPE) and other outbreak supplies on hand at all times. The emergency stock is monitored and managed by the IPAC coordinator in collaboration with the home's storekeeper and FSM.

All emergency supplies are kept in a dedicated area. When supplies are used, the stock is replenished. Emergency supplies may be used while restocking of supplies is occurring to manage the use prior to the expiration of products.

The emergency stock plan may include supplies required for lab testing such as PCR testing supplies, as well as point of care testing supplies such as rapid tests. These supplies and stock needs may vary based on the disease of public health significance. The Director of Nursing and IPAC Coordinator will need to work together to determine the best approach to manage the ordering and tracking of these supplies to ensure that nurses are able to obtain specimens in a timely manner in the home.

The following procedure outlines the supply management procedures to follow:

IPAC Supply Management Plan for Pandemic

Pioneer Ridge Central Stores (PRCS) has a dedicated FT Storekeeper Receiver (S/R) Monday-Friday who is responsible for purchasing, receiving and issuing all consumable products in the home.

PRCS also provides products as requested to Jasper Supportive Housing, and the CTB run childcare centres (Grace Remus (onsite), Algoma, Woodcrest and Ogden).

The S/R to the Manager of Nutrition & Food Services (FSM) who also acts/assists in procurement of all products for the various departments in the home.

Inventory Management – regular stock, pandemic stock

- Departments in the home request products on their weekly orders or by email or phone
- S/R fills orders and delivers as per schedule.
- S/R does weekly inventory of regular par levels and places orders with vendors to replenish.
- Pandemic stock is kept separate from regular stock. Expiry dates are monitored and pandemic inventory that is within 6 months of expiry is transferred to regular inventory. Pandemic stock is then replenished.
- Quarterly or as needed depending on outbreak statuses, a full inventory of pandemic stock is taken.
- Jasper, childcare centres request supplies on a weekly basis or as needed basis by email
- 4 PPE caddies are stocked and available to staff to grab during off hours.

Inventory Management during outbreak

- Upon declaration of an outbreak, depending on number of caddies needed, the S/R assembles PPE caddies for distribution with regular stock as much as possible. Pandemic stock is put into use if needed.
- Orders to replenish both regular and pandemic stock are put in immediately with designated suppliers.

- FSM and/or S/R procures supplies from other vendors if there are product shortages from regular suppliers.
- FSM or S/R accesses CTB Electronic Storefront to determine if there is stock available.
- IPAC Coordinator requests supplies from Ontario PPE Supply Portal if shortages are experienced.

RAT, PCR Inventory Management

- IPAC Coordinator with the assistance of the S/R conducts regular inventory of RAT, PCR test kits.
- IPAC Coordinator completes and submits weekly a RAT Burn Rate report to CTB Stores. Burn rate includes Pioneer Ridge and Jasper Supportive Housing
- Based on current and/or anticipated burn rate of RATs, IPAC Coordinator requests kits from the Ontario Health PPE Portal keeping a minimum of 21-day supply
- An inventory of 450 PCR test kits is kept onsite to enable 3 full rounds of PCR testing for the facility.
- Based on usage and inventory, PCR test kits are requested through the Ontario Health PPE Portal

The suppliers may vary based on supply and demand, changes in procedures to obtain pandemic supplies as identified above. The home will obtain supplies from its main supplier of PPE and utilize other sources as required based on general supply and demand issues related to the emergency.

The home's IPAC emergency response team will meet regularly and discuss the status of supplies. In the event of a risk of supply shortages, the NFS manager will work with the IPAC coordinator and Director of Nursing to provide further guidance to front line staff as necessary on alternate measures as a last resort.

*Refer to the excel spreadsheet for details regarding IPAC supply inventory and suppliers updated in June 2022.

Appendix S: Temporary Resident Relocation

The home's goal is to allow all residents to remain in their rooms/resident home area where they are most comfortable; with their personal belongings and staff who know them best.

In the event residents must be relocated temporarily to another space based on identified need/risk, the home will provide the following options as applicable/available:

1. Relocate a resident to a vacant room on the same home area, if available and no others on the home area require movement.
2. Relocate a resident off site, to a caregiver's home.
3. Relocated a resident to a designated space in the home.
4. Relocate a resident to a designated space off site, managed by the home.

Vacant Room

If there is an identified benefit of moving a resident to a vacant room on the same home area, to reduce their risk of additional exposure to a positive roommate; the home may consider presenting this option to the resident and/or substitute decision maker.

This temporary measure would only be considered if there is more benefit than risk of disrupting a resident's routine, comfort in their own space. This measure will not change the fact that a close contact/roommate may still require isolation and additional precautions.

Relocating to a caregiver's home

This temporary relocation measure is not to be offered to a resident's family/caregiver by staff. The home is the service provider for all residents. Relocating a resident in this case requires the home to develop a detailed plan to ensure that the resident will continue to have their needs met.

This measure would only be considered in the event a resident or SDM requests it. If this is requested by a resident and/or SDM, this request should be directed to the home area CNM and Director of Nursing.

Designated Space in the Home

At Pioneer Ridge, the dedicated internal space for resident relocation would be the Auditorium which is located on the 3rd floor. The set-up guidelines for this space are included further in this document.

The need to relocate to a space outside of the home would follow the plan outlined in home's evacuation plan. This measure would be a last resort effort; if the home determines there is a need for one more additional space to provide treatment for illness and the auditorium is beyond capacity and other spaces such as living rooms/activity rooms have been deemed unavailable.

The following measures will be put in place when residents are relocated to the Auditorium, which would be treated as a 'pandemic treatment area'. This will be utilized when there is a need to separate residents affected/at risk from the general resident population.

- This area will be staffed with dedicated employees who will be assigned to this area for as long as required to limit the risk of spread in the home.
- Dedicated equipment and physical space dividers will be placed in the auditorium.

- A space for each individual resident will be set up with a bed, bedside table and a manual call bell.
- The treatment area will be staffed with at least 1 RPN and 2 PSWs on all shifts with a RN available to attend the area based on need.
- A private documentation centre will be set up with resident charts, care binders, documents near the front of the Auditorium where the phone is located.
- Meals will be delivered to this area through the service elevator on a cart with trays. Meal trays will be provided to residents in their individual space.
- The locked storage area in the auditorium will be converted to a medication room for a medication cart and treatment supplies.
- A space may be considered for small group exercises/activities with therapeutic recreation. If this is not feasible based on the type of illness, 1:1 sessions may be provided by dedicated TR staff
- Electronic tablets will be made available to facilitate video calls between residents their family and friends.
- Visitors will be limited to 1 per resident, unless otherwise determined based on the identified causative agent. Any visit will be limited to the individual resident's space.
- Visitors will be shown what PPE to use during a visit, with instructions on proper use, hand hygiene, proper disposal.
- Special considerations will be given in situations where a resident is receiving end of life care, or when assistance from a designated essential caregiver is required.
- Clean and dirty supplies will be kept in separate areas with courier service through the service elevator and/or outside the auditorium doors.
- Additional PPE/pandemic supplies will be provided on a cart placed on the outside of the auditorium back door. Smaller supply carts will be placed in the auditorium for regular use.
- Each resident area will have signage with precautions, point of care hand sanitizer, hand wipes, dedicated equipment such as basins, PPE cart, sanitizing wipes, dirty laundry, and garbage bins.
- Each resident will be set up with a dedicated commode for toileting.
- Bed baths will be provided while a resident is in this area; consideration to allow to attend a designated home area bath/shower will be based on the identified illness. The movement to the shower/bath will be limited to the 3rd floor and measures will be placed to reduce the risk of exposure such as wearing PPE during transportation/cleaning and disinfecting of surfaces in the shower/tub room.
- Floor lifts will be dedicated to use in the Auditorium based on population needs.
- Air purifiers will be placed in the auditorium for respiratory illnesses.

The OMT team will work in collaboration with the front-line staff, residents and/or their SDM when planning relocation to a dedicated space such as this one. Each resident's needs should be considered, including risk of elopement and potential for increased behaviours/confusion.

Residents who live in private rooms may not have to move to the dedicated space based on the illness and risks. Discussions will be held to determine individual needs versus risk to the unaffected resident population.

Relocation of Residents beyond the dedicated area

The relocation of residents will always be a measure of last resort, especially when movement is considered to be made off site.

When the capacity to manage an area for ill residents has been exhausted beyond the auditorium, the IPAC management team may consider the use of meeting spaces such as the classroom or boardroom.

The team may also consider assigning an entire home area and the auditorium as locations to treat affected residents in the event of a pandemic where a large number of residents are affected at once, over various home areas where control is required to be expanded. The auditorium and home area 3 are the dedicated spaces to allow for this to occur.

As an extreme, last resort effort, the home may consider collaborating with the COTB to set up a site in a local facility such as community centres and/or arenas with transportation services involved in the movement of residents and equipment.

All measures implemented in the set up of the auditorium space will be used in the event of mass resident movement.

Dedicated Space – 3rd Floor Auditorium

(Set up and equipment guidelines)

Equipment needed:

- Dedicated vital sign and assessment equipment (thermometer, BP cuff, O2 monitor, glucometer, stethoscope)
- Oxygen equipment (tanks, O2 masks, nasal prongs, nebulizers, nebulizer masks)
- IV equipment (poles, pumps, 3M command hooks to use in place of poles, tubing, saline, SC sets, syringes)
- Medications (storage area, lock box, med cups, pill crusher, syringes, alcohol swabs, ensure)
- PPE (gowns, gloves, masks, shields, hair cover, foot covers)
- Wound/dressing supplies
- Fridge for medication requiring refrigeration, drinks and snacks for residents
- Computer (COW)
- Call bells or hand bells
- Phone
- Device to Facetime with families
- Linen (bedding, soakers, towels, cloths, hospital gowns, resident's clothes)
- Basins, soap, periwash, any stock or Rx creams, briefs
- Commodes, bed pans
- Resident charts
- TV or radio, other activities for residents who are able

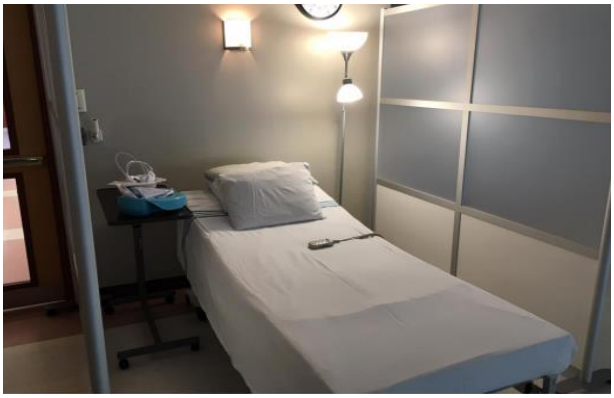
Resources needed:

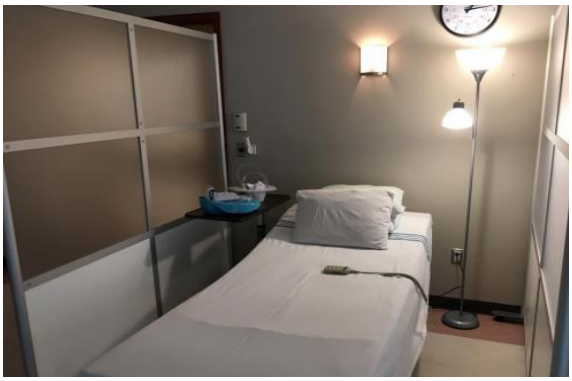
- Copy of standing orders
- Important phone numbers, MD/NP phone numbers
- EOL order sheet, comfort round sheet
- Pallium Goals of Care resource

Logistics:

- Meals and dishes (disposable vs bagging tray)
- Housekeeping plan (delegated to nursing working area or alternate plan)
- 1 washroom for dirty (to be used to empty commodes and bed pans)
- 1 washroom clean (staff use, changing area)
- PT room or hairdresser room (staff break area)
- PPE set up area

Room set up photos





Appendix T: The Management of Outbreaks

Disclaimer: This policy, procedure and applicable protocols are subject to change based on the Disease of Public Health Significance and applicable public health guidelines.

Signs and Symptoms of illness in the General Population

New, worsening, or different from an individual's baseline health status (usual state). Symptoms should not be chronic or related to other known causes or conditions.

Common respiratory symptoms include:

- Fever (temperature of 37.8°C/100.0°F or greater)
- Cough (that is new or worsening)
- Shortness of breath
- Sore throat (painful swallowing or difficulty swallowing)
- Rhinorrhea (runny nose)
- Nasal congestion (stuffy nose)
- New olfactory or taste disorder (decrease or loss of smell or taste)

Common gastrointestinal symptoms include:

- Nausea and/or vomiting
- Diarrhea
- Abnormal temperature for resident
- Abdominal pain that is persistent or ongoing
- Abdominal tenderness

Other signs and symptoms of an acute illness should be considered in older persons living in LTC. These may include the following:

- Chills
- Headache that is new and persistent, unusual, unexplained, or long-lasting
- Conjunctivitis (pink eye)
- Fatigue, lethargy, or malaise (general feeling of being unwell, lack of energy, extreme tiredness) that is unusual or unexplained
- Myalgia (muscle aches and pain) that are unexplained, unusual, or long
- Decreased or lack of appetite
- Delirium (acutely altered mental status and inattention)
- Increased number of falls in older persons
- Acute functional decline (a sudden change in ability to function compared to baseline)

Case Definitions

Consider the following if a resident presents with symptoms. The local public health unit holds authority to declare an outbreak; the definitions below are to assist in decision-making.

Resident Case definitions:

Gastrointestinal: 2 or more episodes of vomiting and/or diarrhea AND/OR a combination of vomiting and diarrhea within 24 hours

Respiratory: 2 or more respiratory symptoms OR lab confirmed infection

Outbreak Case Definitions:

Suspected Respiratory Outbreak

2 cases with a common epidemiological link within 48 hours OR 1 laboratory confirmed case of influenza or Covid-19

Declared Respiratory Outbreak

3 or more cases with a common epidemiological link within 48 hours OR 2 cases of influenza or Covid-19 with one being laboratory confirmed (molecular or RAT)

Suspected Gastrointestinal Outbreak

1 case meeting case definition (symptoms not attributed to another cause)

Declared Gastrointestinal Outbreak

2 or more cases with a common epidemiological link within 48 hours.

Surveillance

Enhanced measures for monitoring and reporting symptoms are in place.

Any resident exhibiting symptoms should be considered as potentially infected with a communicable illness.

RNs and RPNs must monitor residents each shift for signs and symptoms of illness, or changes in condition.

Any changes in status of a resident must be documented in their medical record and monitored – as well as communicated on the 24-hr report/shift change report.

Any resident reporting and/or exhibiting symptoms will be assessed by the RPN on duty.

Upon suspicion of potential for respiratory or gastrointestinal illness, the RN will be notified.

Testing

Residents presenting with symptoms should be tested within the acute stages of illness to identify the causative agent as soon as possible.

A nasopharyngeal swab PCR should be collected and sent to the lab for all respiratory cases.

A stool sample should be collected during when a resident has gastrointestinal symptoms using an enteric outbreak kit.

The specimens must be placed in the specimen collection fridge for pick up prior to 1 pm weekdays.

Specimens collected on weekends must be sent to the public health lab with the nurse manager on call when deemed necessary.

Results of public health laboratory tests are normally received at the secure fax machine in the main business office. Confidential faxes sent to this area must only be accessed if directed by the nurse manager on call after hours.

Depending on the nature of the disease of concern, testing may also be required for close contacts of cases. This would be done based on current public health recommendations/guidelines.

Case/Contact Management

Any resident reporting and/or exhibiting symptoms will be asked to isolate in their room with contact-droplet precautions (respiratory) or contact precautions (GI) in place. Airborne precautions will be implemented in cases where risk of airborne transmission of a novel virus has been identified.

Signage indicating the type of precautions required will be posted outside the resident's room prior to entry.

A PPE door caddy, dedicated soiled linen and garbage receptacle will be placed at the resident's room by the RN/RPN or delegate.

The resident and/or substitute decision-maker will be informed of the need to isolate and implement additional precautions at this time.

Laboratory testing will be performed with the consent of the resident and/or substitute decision-maker.

The RN and RPN will have to determine whether high risk contacts exist, such as a roommate or tablemate of the resident presenting with symptoms. These individuals should be monitored closely for symptoms. Isolation to room and testing may be indicated based on public health guidelines.

Additional precautions and isolation must remain in place until results are received.

Follow up testing requirements will be based on public health guidelines for the novel virus.

Monitoring Line List

When a resident on a home area present with signs and symptoms of illness, the RN should initiate a 'Monitoring' line list to assist with the tracking of resident cases.

The line list used is the *Resident Respiratory Outbreak Line list* for respiratory cases OR Resident *Gastrointestinal Outbreak Line list* for GI cases. At this point, there is no outbreak declared; therefore, the monitoring list is only meant for tracking purposes.

All resident information should be entered as indicated on form.

Declared Outbreak

If the local public health declares an outbreak; it is normally due to the fact there are at least 2 or more confirmed cases of the illness. Please note: Outbreaks may be declared for 1 case in the early stages of a pandemic.

The public health nurse will provide the home with an outbreak number, which will be used to track any specimens sent that are linked to the outbreak. All laboratory requisitions will need to include the dedicated outbreak number.

Testing guidance will be provided by the public health nurse during the initial outbreak discussion.

Laboratory specimen collection will begin as soon as possible on actively ill residents. The total number of specimens to be collected will be determined by public health, based on the disease of concern.

The Nursing Unit Support Worker will assist in labelling and preparing test kits when able.

The RN and RPN on the home area will contact residents and/or their substitute decision-makers to obtain consent for the initial outbreak testing per public health requirements.

Consents will be documented in the resident's medical health record.

Initial testing will be done by the home area nurses, with assistance from other home nurses as required. All specimens will be placed in the laboratory fridge in the communication room on the 3rd floor weekdays prior to 1 pm.

Testing on residents who have been recently positive may not be recommended, based on the nature of the disease of concern, as some viruses may still be detected some time post-infection.

Specimens collected during weekend hours will be placed in the laboratory fridge based on recommendations. If a specimen will not remain stable over the weekend, it will need to be transported to the public health lab by the manager on call.

Any resident presenting with symptoms during the outbreak will be monitored closely and placed in isolation with additional precautions promptly to reduce further risk of spread in the home area.

Isolation and additional precautions will remain in place for a minimum number of days (based on public health guidance) from the onset of symptoms or positive test, whichever is sooner.

Communication about the outbreak will be sent to POAs and essential caregivers in the home by the home's administration.

Visits will be limited to essential caregivers during declared outbreaks.

Essential caregiver and staff working in areas affected by outbreaks will follow routine IPAC measures but wear appropriate PPE when within 6 feet of residents with symptoms, close contacts or known infection.

Guidance and education on the use of PPE for essential caregivers is completed when they register but may need to be reviewed on the spot with nursing staff during a declared outbreak if the need is identified.

Outbreak Line Listing

Line listing for the outbreak will be initiated and will only include residents who meet the case definition.

The line list will be kept on the RN 24 hr report board, or dedicated line list board on the affected home area.

The line list will include the outbreak number, fax number and home area affected. The line list will be updated every 24 hours, with the date at the top updated after daily faxing/copying.

The RN on day shift will be responsible for faxing the outbreak line list to the public health unit before 8 am each day, including weekends.

When faxing the outbreak line list, a copy will be made for the Director of Nursing and IPAC coordinator. The copies of these lists will be placed in their mailboxes in the communication room.

The RNs will be responsible for communicating any changes in the outbreak status with the nursing managers.

Staff line lists will be initiated as soon as a staff meets case definition. This line list will be updated for each new case, faxed to the health unit daily with copies to applicable team members as above.

Outbreak Supply Management

During the initial presentation of resident cases, the RN may access pre-curated PPE caddies from the Stores room.

Once an outbreak is suspected or declared, the RN or delegate will call the storekeeper on duty, weekdays before 2 pm to obtain an outbreak cart. An after-hours outbreak cart is readily available in the penthouse – 5th floor – which can be accessed by the service elevator.

The outbreak cart will consist of ample PPE and outbreak supplies, including additional caddies for resident rooms.

The home area staff will be responsible for stocking all caddies before the end of each shift with this cart and place the cart outside the home area doors before 7 am each day to have supplies replenished by the storekeeper.

Any additional supply needs will be communicated with the storekeeper.

In the event of after-hours needs, and the caddies in stores not being sufficient, the nurse manager on call should be informed as soon as possible.

It is the responsibility of the staff working on the affected home area to evaluate and communicate supply needs with the storekeeper during their weekday hours to ensure adequate supplies are available. Consideration must be given to the number of residents affected as well as oncoming weekend needs.

Once a resident is no longer requiring additional precautions, the home area staff will be responsible for emptying the door caddy and distributing the remainder of the supplies to the remainder of caddies on the home area.

The emptied caddy can be placed in a clear plastic bag and returned to the storekeeper after use.

Outbreak Meetings

The home's outbreak management team will meet regularly during a confirmed outbreak.

The meeting will be chaired by the IPAC coordinator, or delegate. The meeting will include the local Medical Officer of Health or delegate, Administrator, DON, each department manager as well as the RNs working on the meeting day.

Meeting minutes will be taken and shared with all attendees.

The IPAC coordinator will send outbreak status updates to the home's staff as well as POAs/ECGs with the assistance of the administrative assistant after each outbreak meeting.

Declaring Outbreak Over

The public health unit nurse is the only person with the authority to declare an outbreak over.

This decision will be made based on the outbreak status, including the timeline since positive cases or symptoms, the absence of severe outcomes, etc.

The home may have concurrent outbreaks in different home areas, which have their own start and end dates.

Once the health unit confirms an outbreak over, communication will be sent to all home's staff, POAs and ECGs.

An outbreak debriefing will be completed by the IPAC coordinator at the end of each outbreak. The goal being to review what went well and what could be improved for future outbreaks.

Appendix U: Visitors & Essential Caregivers

During pandemics, endemics and diseases of public health significance, the home's goal is to promote resident interaction with their loved ones while minimizing risk of transmission of these illnesses into the home.

For new/unknown viruses, the home may make the decision to limit entry to essential caregivers such as employees and publicly funded/private paid healthcare workers/caregivers. The goal is to prevent a full closure as we know the impact it may have on the residents who live in the home.

In the event of a full closure, the home will promote meaningful visits with family and friends by utilizing other measures such as phone or video calls as well as arranging window visits. Care would be taken to consider special circumstances such as allowing visitors at end of life.

During outbreaks in the home, or IPAC emergencies, the home will provide information to visitors on how to protect themselves when visiting with basic IPAC measures. The information found in Appendix G "IPAC Resources and Guidance" will be shared with families as well as on the spot education as needed.

The home will follow the visitor policy below when making decisions regarding visitation during the covid-19 pandemic. The following policy would be used as a baseline approach in managing visitors in the home during outbreaks.

Visitor Policy

*The policy below is an example of the policy used during the covid-19 pandemic; it can be modified for use as required.

Pioneer Ridge understands the needs and the rights of residents related to visitation, social interaction, and emotional support.

All visitors' guidelines and protocols for visitation, including visiting hours will be reviewed and revised as needed referring to any current or new Ministry directives, guidance documents or any other relevant resources and best practices.

Non-compliance with the home's policies could result in a discontinuation of visits for the non-compliant visitor. (see protocol *Responding to non-adherence by visitors in the home)*

****This policy is subject to change or override based on directives from the Ministry of Health, Ministry of Long-Term Care or Public Health****

Visiting Hours

Visiting hours for General Visitors are between 8:00am and 8:00pm daily.
Essential Visitors, including Caregivers may visit outside of these hours.

Types of Visitors

LTC home staff, volunteers and students are not considered visitors as their access to the home is determined by the licensee.

General Visitors

A ***general visitor*** is a person who is not an essential caregiver and is visiting:

a) To provide non-essential services, who may or may not be hired by the home or the resident and/or their substitute decision maker (i.e. contractor, phone or cable installation, etc.)

b) For social reasons (e.g., family members or friends) including cognitive stimulation, meaningful connection and relational continuity but not involving any direct care

Essential Visitors

A ***caregiver*** is a person who is designated by the resident and/or their substitute decision-maker and is visiting to provide direct care to the resident (e.g., supporting feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity, and assistance in decision-making). This can be a family member or friend, or a paid support worker (i.e. dental hygiene, foot care, etc.)

*Note: Any individual younger than 16 years of age must receive approval from a parent or legal guardian to be designated as a caregiver.

Other **essential visitors** include support workers, government inspectors or any person who is visiting a resident who is very ill or end-of-life.

PROCEDURE:

Visitation Guidelines

A maximum of **4 visitors** per resident may visit at a time, provided the home is not in an outbreak and the resident is not self-isolating or symptomatic. This can be a combination of general visitors and caregivers.

Essential Caregivers

Essential Caregivers are required to provide proof of full immunization for COVID (or other communicable diseases as may be required).

Full immunization for COVID requires the primary series doses (1 or 2 depending on type) and a third dose (booster) as authorized by Health Canada.

Essential Caregivers are required to complete education on proper infection control practices and the use of personal protective equipment (PPE).

They must follow all applicable infection prevention and control (IPAC) precautions that are in place at the home (universal masking, screening, testing, PPE etc.).

Essential caregivers will be provided education by the home once they meet the requirements, and this is approved by the home.

Essential Caregivers will be permitted to visit if the home is in an outbreak, or the resident is self-isolating or symptomatic, with the following stipulations:

- A maximum of 2 caregivers per resident may visit at a time; and
- A caregiver may not visit any other resident or long-term care home for 14 days after visiting a resident who is self-isolating or symptomatic; and/or a home in an outbreak.

General Visitors

General visitors who choose to provide proof of immunization for Covid-19 will be considered fully immunized as long as they have received the primary series of the vaccine (1 or 2 depending on

type). Booster doses are highly recommended.

General visitors are NOT required to provide proof of immunization for Covid-19 (or other communicable diseases as may be required), however if proof of immunization is not provided, the visit will be restricted to the resident's room OR outside locations as long as 6 feet of distance is maintained from others.

General visitors younger than 14 years of age must be accompanied by an adult.

General visitors must follow all applicable infection prevention and control (IPAC) precautions that are in place at the home. (Masking, screening, testing, PPE etc.)

If a resident is self-isolating or symptomatic, or the home is in an outbreak general visitors are NOT permitted entry.

Exceptions may apply to contractors (general visitors) if it is determined by the home that the service provided is essential to the operation of the home or the benefit of the resident.

Non-Adherence to Rules/Ending or Suspending Visits

Pioneer Ridge has the discretion to end a visit by any visitor who repeatedly fails to adhere to the home's visitor policy. In the event of repeated and flagrant non-adherence with the home's visitor policy, we maintain the discretion to temporarily prohibit a visitor (suspend the visits).

If an employee notices a visitor not following the requirements, they should provide a friendly and respectful reminder to the visitor. If the visitor is not wearing PPE appropriately, the employee should offer to demonstrate or assist. If the non-adherence to rules becomes more frequent, and the visitor has already received coaching or reminders on multiple occasions, the employee shall report this information to the Director of Nursing or designate.

Prior or to ending or suspending visits, the Director of Nursing or designate will follow the home's protocol "*Responding to non-adherence by visitors in the home*" which provides strategies for supporting visitors in understanding and adhering to the home's visitor policy.

Recognizing that visits are critical to supporting a resident's care needs and emotional well-being, any decisions to end or suspend visitation will be made by the Director of Nursing or designate after careful consideration the impact of discontinuing visits on the resident's clinical and emotional well-being and only after exhausting other options.