5 Resurrection Rd. Toronto ON M9A5G1
Tel. 416-232-2112 • Fax 416-232-0511

Pandemic Plan

2022-23

1.0 PURPOSE:

During the 20th century, the world experienced three influenza pandemics. The deadliest, the "Spanish Flu" of 1918-19, killed 40 to 50 million people worldwide. Most recently, COVID-19 continues to be the greatest threat to the population with a pandemic life span that is uncertain and a virus that continues to mutate and persist. Worldwide, contagious diseases from all sources, not limited to influenza, can trigger a pandemic although the prevalence of a pandemic occurring relating to influenza is recognized by the World Health Organization as the most likely catalyst. Continued pandemic planning and infection prevention will help to reduce:

- the number of people infected (i.e., the extent of the outbreak),
- the amount of illness, the number of deaths,
- and the level of socio-economic disruption.

Every jurisdiction must be prepared to mobilize resources quickly and effectively to limit the impact of a pandemic.

1.1 DEFINITION

An Influenza Pandemic or a Pandemic flu is virulent human flu that causes a global outbreak, or pandemic, of serious illness. Because there is little natural immunity among humans, the disease can spread easily from person to person. The World Health Organization has provided a template for tracking the unfolding of a pandemic outbreak that has been adopted by the Canadian and Ontario governments to guide their respective pandemic planning.

World Health Organization – Pandemic Template

Period	Phase	Description
Inter-pandemic Period	***Phase 1***	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection is considered to be low
	Phase 2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
Pandemic Alert Period	***Phase 3***	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
	Phase 4	Small cluster(s) with limited human-to human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.
	Phase 5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).
Pandemic Period	***Phase 6***	Increased and sustained transmission in general population.
Post-pandemic Period	***Phase 7***	Return to inter-pandemic period

Source: World Health Organization, 2005

1.2 About Influenza

Influenza is a contagious respiratory illness caused by a group of viruses: influenza A, B, and C. Most seasonal influenza epidemics are caused by types A and B; type C rarely causes human illness. Influenza can cause mild to severe illness. It usually starts suddenly.

Common symptoms include: fever (usually high, lasting 3 to 4 days); headache (often severe); aches and pains (often severe); fatigue and weakness (can last 2 to 3 weeks); extreme exhaustion (very common at the start); stuffy nose; sneezing, sore throat, chest discomfort and cough; and nausea, vomiting and diarrhoea (in children).

Many different illnesses, including the common cold, can have similar symptoms. While most healthy people recover from influenza without complications, some people – such as older people, young children, and people with certain health conditions – are at high risk for serious complications from influenza. Some of the complications caused by influenza include: pneumonia (bacterial or viral), dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes. Children and adults may develop sinus problems and ear infections.

A highly infectious disease, influenza is *directly* transmitted from person to person primarily when people infected with influenza cough or sneeze, and droplets of their respiratory secretions come into contact with the mucous membranes of the mouth, nose and possibly eyes of another person (i.e., droplet spread).

Droplets expelled during coughing or sneezing can be inhaled by someone who is within two metres of the coughing or sneezing person (short-range transmission). Because the virus in droplets can survive for 24 to 48 hours on hard non-porous surfaces, for 8 to 12 hours on cloth, paper and tissue, and for 5 minutes on hands, it can also be transmitted *indirectly* when people touch contaminated hands, surfaces and objects, and then touch their face (i.e., contact spread).

The incubation period for influenza is from 1 to 3 days. People with influenza may be able to transmit the virus for up to 24 hours before symptoms appear. Adults are infectious for 3 to 5 days after symptoms appear while children are infectious for up to 7 days after symptoms appear.

Case Definition for Influenza Like Illness (ILI) in the General Population

Acute onset of respiratory illness with fever and cough and with one or more of the following – sore throat, arthralgia, myalgia, or prostration, which could be due to influenza virus. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.
Source: Fluwatch (national case) definition for the 2006-2007 season Ontario Health Plan for an Influenza Pandemic August 2008 Chapter #1: Background 1- 2

A pandemic influenza is distinguished from seasonal influenza by its scope combined the ease and rapidity with which it is spread. Pandemic flu appears very similar to seasonal flu but spreads more quickly because people have little or no immunity to the pandemic virus. Seasonal flu typically affects the immuno-compromised but pandemic flu affects people across all age groups and health status. The death rate was highest among healthy adults during the pandemic outbreak of the early 1900's.

Ordinary (Seasonal) flu	Pandemic flu
Occurs every year	Occurs only 2-3 times per century
Typically emerges in November ending in April	Pandemic flu hits in 2 or 3 waves several months apart, each incident lasting for 2-3 months
Approximately 10% of people in Ontario contract the flu each year	It is expected that approximately 35% of Ontarian will contract pandemic flu over the course of an outbreak
Those who contract seasonal flu will recover within a couple of weeks	About half the people who get pandemic flu will get sick. Most will recover but it may take a long time. Some will not survive.
The immuno-compromised, the very young, the very old and people with certain chronic illness, are the most seriously affected by seasonal flu	Depending on the virus, people of any age or health status may become seriously ill depending on the virus
Up to 2,000 people in Ontario die each flu season due to complications from the flu such as, pneumonia	Ontario would see many more people infected and possibly more deaths
Annual flu shots are effective in protecting people from most flu strains	Vaccination development may be possible. At the onset of a new pandemic flu strain, there would be no existing vaccine for pandemic flu.
People may be treated with drugs combat flu	These same drugs may help those infected with the pandemic flu but the supply may not be enough to address all the cases and the effectiveness will not be known until the strain is identified

COVID -19

COVID-19 Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV), Severe Acute Respiratory Syndrome (SARS-CoV), and COVID-19. COVID-19 is a novel coronavirus, a new strain that has not been previously identified in humans. On March 11, 2020, the WHO announced that COVID-19 is classified as a pandemic virus.

COVID-19 has spread around the world, affecting every country directly or indirectly. Its capacity for rapid spread and mutation means COVID-19 has sometimes overwhelmed even the most resilient health systems. As of July 2022, more than 4 million cases had

been reported in Canada with a death rate of 42,253 and in Ontario specifically, more than 1.35 million cases had been reported with a death rate of 13, 527. The greatest population experiencing deaths related to COVID-19 occur in individuals over the age of 65 years. Limiting transmission and incidences of cases and outbreaks is paramount to the well being of the Residents supported and their caregivers.

COMPARING COVID-19 AND INFLUENZA		
COMPARISONS	COVID-19	INFLUENZA
Disease Presentation	Generally respiratory in nature although GI symptoms may be prevalent and/or minor symptoms or no symptoms. Unique presentations include loss of taste and smell.	Generally respiratory in nature. GI symptoms may also be present. Sore throat is not uncommon along with general respiratory symptoms.
Transmission	Transmitted by contact, droplets and fomites.	Transmitted by contact, droplets and fomites.
Speed of Transmission	Longer incubation period therefore symptoms may be slower to present.	Shorter incubation period therefore faster presentation of symptoms.
Time between successive cases	On average 5 – 6 days apart	On average 3 days apart
Prevalence of severe disease	Higher than Influenza	Lower than COVID-19
Most at Risk Population for severe disease response	Older adults, those persons with underlying conditions and immunosuppressed.	Children, pregnant women, elderly, immunosuppressed and underlying conditions.
Mortality Rates	Higher than influenza (Between 3-4% of reported cases)	Lower than COVID-19 (Below 0.1% of reported cases)

(Source: World Health Organization March 2020)

2 Principles of Containment and Infection Control

2.1 Infection control assumptions

The principles of infection control for pandemic infections assume that pandemic infections have similar properties to influenza seasonal outbreaks and as such the following are assumed:

- Person to person spread of human influenza viruses is well established
- The patterns of transmission observed during the outbreaks of influenza in healthcare settings suggest that droplet and contact (direct and indirect) are the most important and most likely routes of spread and a known form of transmission for COVID-19.
- In the case of some pathogens, aerosols generated under specific circumstances may be associated with an increased risk of pathogen transmission. This may be more prevalent with COVID-19 and as such adherence to recommendations made

from local Public Health Units, FLTCHA, 2021 and MOHLTC Guidance documents will be resourced. While this may be possible for influenza, the consensus is that droplet and contact transmission are of far greater importance.

- Adults will usually be infectious for up to five days after symptoms begin although longer periods of virus shedding have been found.
- Virus excretion may be considerably longer in immuno-compromised residents.
- Based on the similarities of symptoms between seasonal influenza and COVID-19, enhanced environmental cleaning is required.
- Hand hygiene is a primary intervention to breaking the chain of transmission for viruses. Washing with soap and water, alcohol hand rub are key to infection prevention.

Assumptions for Pandemic Planning and Response (from OLTCA Magazine)

- A pandemic affects the entire health care system and the community. Hospitals, local public health units and other services will have limited capacity. Long Term Care Home may not be able to rely on the same level of support they receive now from other parts of the health care systems or from other community systems during an outbreak.
- This pandemic plan will be coordinated with the plan of other organizations in the community and local/regional pandemic plans and follow the most recent directives supported by the World Health Organization, MOHLTC guidance and Public Health.
- The number of health care workers may be reduced by as much as one third due to personal illness, concerns about transmission in the workplace and family/care-giving responsibilities.
- Usual source of supplies may be disrupted or unavailable.
- To meet community needs during a pandemic outbreak, resources – including staff, supplies and equipment, may have to be reassigned or shifted.
- Care protocols may change, and practices may have to be adapted.
- Long-term care homes will need effective ways to communicate with residents' family and friends to meet their needs for information but reduce the demands on staff.

A Guide to Influenza Pandemic Preparedness and
Response in Long Term Care Homes
Emergency Management Unit,
Ministry of Health and Long-Term Care
December 2005

2.2 Principles of containment and infection control

Limiting transmission of pandemic viruses in the healthcare setting requires:

- Timely recognition of cases – screening & testing protocols in place specific to COVID-19.
- Instructing staff members with respiratory symptoms to stay at home and not come to work and being tested as appropriate to presentation of symptoms specific to COVID-19.
- Cohorting of staff as much as possible
- Consistently and correctly implementing appropriate infection control precautions to limit transmission (standard infection control principles and droplet precautions)
- Using personal protective equipment appropriately according to risk of exposure to the virus
- Maintaining separation in space and/or time between actively infected and non-infected residents – designated isolation rooms.
- Restricting access of visitors to the facility in accordance with applicable guidelines and legislation.
- Environmental cleaning and disinfection
- Educating staff, residents and visitors about transmission and prevention of infectious virus.
- Vaccinating residents and staff

3 Infection control precautions

3.1 Key points

- Standard infection control principles and droplet precautions must be used for residents with or suspected infection consistent with relevant IPAC guidelines.
- Good hand hygiene among staff and residents is vital for the protection of both parties.
- Good respiratory hygiene is essential.
- The use of PPE should be proportionate to the risk of contact with respiratory secretions and other body fluids and should depend on the type of work or procedure being undertaken and Point of Care Risk Assessment (PCRA) outcome.

3.2 Infection control precaution for pandemic influenza and/or COVID-19.

Standard infection control principles and droplet precautions must be used for residents with or suspected of having pandemic infection including any enhanced guidelines specific to COVID-19 as directed by MOHLTC guidelines, FLTCHA, 2021 and Public Health regulations. Standard infection control principles are a set of broad statements of good practice to minimize exposure to and transmission of a wide variety of micro-organisms. Standard principles should be applied by all practitioners to the care of all residents all the time.

3.3. Hand Hygiene

Hand hygiene is the single most important practice needed to reduce the transmission of infection in healthcare settings and is an essential element of standard infection control principles.

Hand hygiene includes hand washing with soap and water and thorough drying, and the use of alcohol-based products that do not require the use of water. If hands are visibly soiled or contaminated (for example, contaminated with respiratory secretions), they should be washed with

soap and water then dried. When using an alcohol hand rub, hands should be free of visible dirt and organic material.

Hands must be decontaminated immediately before each-and-every episode of direct care of or contact with residents and after any activity or contact that potentially result in hands being contaminated, including the removal of protective clothing and cleaning of equipment. Hands should be decontaminated between caring for different residents and between different care activities for the same patient, even if gloves have been worn. All staff, residents and visitors should clean their hands when entering and leaving areas where care is delivered.

3.4 Applying droplet precautions for pandemic influenza and/or COVID-19

In addition to standard infection control principles, droplet precautions should be used for a resident known or suspected to be infected with influenza, which is transmitted by droplets that can be generated by the resident during coughing, sneezing or talking and during some procedures.

3.4.1.Resident placement

- Ideally, resident(s) with influenza should be placed in single rooms, but during a pandemic, this will not be possible. Therefore, residents should be cohorted (grouped together with other residents who have influenza and no other infection), in a segregated room or area (unit) of the facility. Isolation rooms will be designated during an active pandemic for the purposes of supporting suspected or proven positive cases of either influenza or COVID-19.
- If residents must share rooms, privacy curtains will be used as separation barriers and the person sharing the room will be considered suspected positive and must remain in isolation for the duration of the infected co-resident and/or negative swab results specific to COVID-19 for both residents sharing a room.

3.4.2. Masks

- Masks must be always worn during work unless eating at which time, tables and spacing between co-workers must be a minimum of 2 meters apart.
- All residents are encouraged to wear masks in common areas during a pandemic
- In the absence of positive cases in the home, while a pandemic is declared, the home will follow MOHLTC guidance and Public Health regulations.

3.4.3 Resident transport

- The movement and transport of residents from their rooms or the cohorted area should be limited to essential purposes only
- If transport or movement is necessary, a mask should be worn during transport until the resident returns to their personal space.
- If a mask cannot be tolerated, then good respiratory hygiene must be encouraged.

3.5 Managing coughing and sneezing

Residents, staff, and visitors should be encouraged to minimize potential transmission through good hygiene measures:

- Cover nose and mouth with disposable, single-use tissues when sneezing, coughing, or wiping and blowing noses.
- Dispose of used tissues promptly in nearest waste bin.
- Wash hands after coughing, sneezing, using tissues or contact with respiratory secretions and contaminated objects.
- Keep hands away from the eyes, mouth, and nose.
- Some persons may need assistance with containment of respiratory secretions; those who are immobile will need a container (i.e. A plastic bag) readily at hand for immediate disposal of tissues and a supply of hand wipes and tissues.
- Where possible, in common waiting areas or during transport, coughing and sneezing residents should wear masks to minimize the spread of respiratory secretions and reduce environmental contamination.
- Follow all COVID-19 specific guidelines and regulations in regard to symptoms management inclusive of screening & testing protocols.

3.6 Personal protective equipment (PPE)

3.6.1 Overview

PPE is worn to protect staff from contamination with body fluids and to reduce the risk of transmission of infectious virus between residents and staff and from resident to another. Appropriate PPE for care of residents with pandemic influenza and/or COVID-19 is summarized in Table 1. Standard infection control principles always apply.

Table 1 Personal protective equipment for care of residents with pandemic influenza and/or COVID-19. Note: Given the similarities between influenza and COVID-19, PPE in cohorted and/or close residents contact may need to remain consistent with an assumption of high transmission and all treated as suspect positive in cohorted areas.

	Entry to cohorted area but no resident contact	Close resident contact (within two metre)
Hand hygiene	Yes	Yes
Gloves	Yes for direct interactions and cleaning	Yes
Isolation Gown	X	Yes
Surgical Mask	Yes	Yes
N95 mask	X	Based on PCRA or as directed
Eye protection	Yes	Based on PCRA or as directed

3.6.2 Eye protection

- Eye protection should be considered when there is a risk of contamination of the eyes by splashes and droplets, for example by blood, body fluids, secretions or excretions or as directed by MOHLTC guidance and Public Health.

- There should be an individual Point of Care Risk Assessment (PCRA) carried out at the time of providing care.

3.6.3 Masks

- Masks should be worn by healthcare workers for any close contact with residents (i.e. within two metres) and at all times in the presence of COVID-19 pandemic.
- Appropriate donning and doffing steps will be followed between residents as directed by Public Health guidelines.

3.6.4 Respirators

Fitting the respirator correctly is critically important for it to provide protection. Every user should fit be fit tested and trained in the use of the respirator. The initial fit test should be carried out by a trained fitter. A good fit can only be achieved if the area where the respirator seals against the skin is clean-shaven. Beards, long moustaches and stubble may cause leaks around the respirator. Other types of respiratory protective equipment (for example, powered hoods/helmets) are available and should be considered if a good fit cannot be achieved with disposable respirators. A powered respirator might be the only type suitable for some, for example someone who, perhaps for cultural reasons, prefers not to remove their beard.
N95 respirators should be replaced after each use and changed if breathing becomes difficult, the respirator becomes damaged or distorted, or obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained. Respirators should be disposed of as clinical (also known as infectious) waste.

3.6.5 Putting on and removing personal protective equipment

The level of PPE used will vary according to the procedure being carried out and the directives provided according to the infectious virus and as directed by the MOHLTC guidelines and directives and Public Health regulations. If full PPE is required, all staff in the room should wear the following PPE. The order given here is practical but the order for putting on is less critical than the order of removal:

1) Gown (or apron)
2) N95 respirator (or mask)
3) Goggles or face shield
4) Disposable gloves

PPE should be removed in an order that minimizes the potential for cross-contamination. Before leaving the area, gloves, gown and eye-goggles should be removed (in that order, where worn) and disposed of as per IPAC protocols. Guidance on the order of removal of PPE is as follows:

1. **Gloves**
   Grasp the outside of the glove with the opposite gloved hand; peel off.
   Hold the removed glove in the gloved hand.
   Slide the fingers of the ungloved hand under the remaining glove at the wrist.
   Peel the second glove off over the first glove and discard appropriately.

2. **Gown**
   Unfasten or break ties.
   Pull gown away from the neck and shoulders, touching the inside of the gown only
   Turn the gown inside out, fold or roll into a bundle and discard.

3. **Goggles or face shield**
   To remove, handle by headband or earpieces and discard or sanitize using anti-viral wipe appropriately.

4 **Respirator or surgical mask**
Untie or break bottom ties, followed by top ties or elastic. Remove by handling ties only and discard appropriately.

To minimize cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.

CLEAN HANDS THOROUGHLY IMMEDIATELY AFTER REMOVING ALL PPE

3.7 Segregation and cohorting

- Cohorting of residents in segregated areas of the home should be carried out from the outset of the pandemic to help contain infection transmission within one part of the home and reduce the risk to other residents.
- A designated self-contained area, designated isolation room or wing of the home should be used for treatment and care of residents with pandemic influenza and/or COVID-19 whenever possible.
  This area should:
  - include a reception area that is separate from the rest of the home and should have, if feasible, a separate entrance/exit from the rest of the home
  - not be used as a thoroughfare by other residents, visitor, or staff, including patient transfers, staff going for meal breaks, and staff and visitors entering and exiting the building.
  - be separated from non-segregated areas by closed doors.
- To control entry, signage should be displayed warning of the segregated influenza area.

3.8 Visitors

- During a pandemic, visitors to all areas of the home will follow MOHLTC guidelines and Public Health regulations.
- Visitors with symptoms should not enter the Home and should be encouraged to return home and comply with appropriate testing protocols.
- All visitors entering a cohorted area must be instructed on PPE protocols and any applicable IPAC protocols.

4 Environmental infection control

4.1 Clinical and non-clinical waste

- No specific procedures beyond those required to conform with standard infection control principles are recommended for handling clinical waste (also known as infectious waste) and non-clinical waste that may be contaminated with virus.
- Waste generated within the clinical setting should be managed safely and effectively, with attention paid to disposal of items that have been contaminated with secretions/sputum (for example paper tissues and masks) in addition to other routine and domestic waste management.

4.2 Linen and laundry

- Both used and infected linen must be handled, transported and processed in a manner that prevents skin and mucous membrane exposures to staff, contamination of their clothing and the environment, and infection of other residents.

4.3 Staff uniforms

The appropriate use of PPE will protect uniforms from contamination in most circumstances. Although there is no conclusive evidence that uniforms pose a significant hazard in terms of spreading infection a theoretical risk exist because influenza virus has been shown to survive for short periods on soft fabrics. Therefore, during a pandemic:

- Healthcare workers should not travel to and from work and places of duty in uniform.
- The facility will provide a changing room or areas where staff can change into uniforms upon arrival at work.
- All staff are expected to change back into street clothes at the end of their shift prior to leaving the building.

4.4 Dishes and utensils

The combination of hot water and detergent used in dishwashers is sufficient to decontaminate dishes and eating utensils used by residents with influenza although disposable pates and cutlery may be considered and utilized for efficiency of service.

4.5 Environmental cleaning and disinfection

- Enhanced environmental cleaning and disinfection will be implemented according to MOHLTC guidelines and Public Health regulations.
- Frequently touched surfaces such as medical equipment, door handles and telephones should be cleaned at least twice daily and when known to be contaminated with secretions, excretions, or body fluids.
- Housekeeping staff should be allocated to specific areas and not moved between positive infectious and negative infectious areas.
- Housekeeping staff must be trained in correct methods of wearing PPE and precautions to take when cleaning cohorted areas. They should wear PPE according to directives specific to the infectious virus.

5 Occupational health and staff deployment

- Prompt recognition of cases of infections amongst healthcare workers is essential to limit the spread of the pandemic
- Healthcare workers with symptoms should not come to work as a general principle.
- Healthcare workers will follow the MOHLTC guidelines and directives, Public Health Regulations, Ministry of Labour legislation and the Home's internal immunization policy regarding influenza.
- Healthcare workers will follow the MOHLTC guidelines and directives, Public Health Regulations, Ministry of Labour legislation and the Home's internal immunization policy regarding COVID-19 and follow applicable Screening & Testing protocols specific to immunization status of the healthcare worker.
- Occupational health departments or providers should lead on the implementation of systems to monitor for illness and absence.
- Occupational health departments or providers should facilitate staff access to antiviral treatment where necessary and implement a vaccination program for the healthcare workforce when required
- As part of their employer's duty of care occupational health departments or providers have a role to play in ensuring that fit testing programs are in place for those who may need to wear N95 respirators.

POLICY

1. Planning for an Influenza and/or COVID-19 Pandemic:

   In our commitment to Resident and staff safety, will strive to:

   (i) Create and maintain a culture of safety within the organization;

   (ii) Reduce the spread of serious illness and overall deaths associated with a pandemic outbreak through appropriate management of service delivery system to minimize service disruption to clients/residents stemming from a pandemic,

   (iii) Create a work life and physical environment that affords staff the best protection possible while supporting the safe delivery of care/service;

   (iv) Improve the effectiveness and coordination of communication among all constituencies, including care/service providers and recipients, other suppliers of material resources and services, government agencies, and the community at large;

   (v) Maintain communication with significant others of residents to reassure and keep informed about the well-being of residents;

   (vi) Have contingency measures to address assurance of continued supply of essential material required for ongoing business operations and delivery of essential services; and

   (vii) Behave as a responsible corporate citizen where community health issues are concerned by coordinating with the implementation of national, provincial and local health systems pandemic plans.

2. An Ethically Sound Approach

   In the event of a pandemic we will act in accordance with policies that are reflective of sound ethical principles that are transparent, and comprehensible to all constituents.

3. A Strategic Approach:

   3.1 In congruence with **Ontario's Health Plan for an Influenza Pandemic** (**OHPIP**) and drawing from resources through The World Health Organization, our Pandemic Policies are based upon the following strategic approach:

   - Be ready

     To plan at the organizational level in anticipation of a pandemic.

     Maintain appropriate IPAC protocols and resources such as IPAC training and auditing, cohorting contingency planning, access and availability of PPE, staff contingency planning including surge capacity & readiness.

   - Be watchful

     To practice active baseline surveillance & testing as applicable and as per infection control policy to identify the earliest signs of a pandemic, and vigilant monitoring throughout the "Active Pandemic Period" inclusive of vigilant resident monitoring for early identification of symptoms consistent with infectious viruses.

   - Be decisive

     To manage the disease spread quickly and effectively with executable outbreak management operating procedures and established partnerships with MOHLTC, local hospital, local Ontario Health Team and Local Public Health unit.

- Be transparent

  To maintain communication with stakeholders through all phases of the pandemic.

3.2 All services/programs operated will be classified either as “Essential” or “Ancillary”. All efforts will be made, including suspending operation of ancillary services/programs and diverting resources as necessary to maintain operation of essential services/programs.

4. Practice Implementation of the Influenza & COVID-19 Pandemic Response Plan on a Regular Basis

   Simulated implementation of all or selected elements of the Influenza Pandemic Response Plan will be conducted periodically, involving key management and other personnel, will be conducted regularly to ensure all are familiar with such policies and procedures.

Procedures:

1. An “**Influenza & COVID-19 Pandemic Planning Committee** (**IPPC**)” **or Outbreak Management Team (OMT)** as directed by the IPAC Lead will be convened in accordance with Policy will formulate and recommend to the Board of Directors (if applicable), Resident Council and Family Council (if applicable) for adoption, as well as regularly review and amend policies that will govern the action of the home in the event of a pandemic flu outbreak.

   1.1 In planning and formulating of policies and procedures, due attention will be given to ethical considerations that are consistent with our values, and congruent with current community standards.

   1.2 Existing infection control and reporting policies and procedures practiced across the organization will be referenced as the basis upon which to establish risk management and containment procedures pertaining to a pandemic flu outbreak context.

   1.3 Input from both management, community partners, Resident Council and Family Council (if applicable), and frontline staff will be considered in formulating all aspects of influenza pandemic policies and procedures.

   1.4 The IPPC or OMT is accountable through the IPAC Lead to the Administrator for the performance of such planning and review functions.

2. **An influenza or COVID-19 pandemic period/outbreak is deemed to be in effect** when the World Health Organization so declares and the Ministry of Health and Long-Term Care (MOHLTC) and/or local (public) health units as designated government agencies advice health services agencies to activate response measures.
3. **In response to a declared pandemic flu outbreak**, the IPAC Lead in conjunction with the Administrator or designate will authorize initiation of Pandemic Policies relevant to the type of pandemic as directed by the Ministry of Health Long Term Care, Ministry of Labour and local Public Health Unit in association with the local Ontario Health Team and as contained in relevant home policies and procedures.
4. The “**Influenza & COVID-19 Pandemic Response Command Team**” **or Outbreak Management Team (OMT)** will assume centralized oversight authority regarding both internal and external matters pertaining to the continued operation of all programs and services during an influenza pandemic.

5. Our responses to an influenza or COVID-19 pandemic will be **coordinated with broader systemic measures** coordinated by the government through the local (public) health units.
6. **Essential services** will maintain operations where human and material resources allow during the Active Pandemic Period.
7. **Priority** will be given to **allocating human and material resources to operate essential services**, even if such must be diverted from services/programs deemed to be ancillary.
8. **Ancillary services/programs** will be suspended to allow the necessary human and other resources to be diverted to sustain essential services.
9. Decisions regarding **suspension of ancillary services/programs and operational resumption** will be made by the Influenza & COVID-19 Pandemic Response Command Team or the OMT and regularly reviewed.
10. A declared **influenza pandemic period is deemed to be in effect** until WHO declares the pandemic is over, and the MOHLTC and local (public) health units issues an official government pronouncement to the contrary; If there were not clear consensus among government agencies, we shall abide by the instructions of the MOHLTC.
11. Until such time as government pronouncement signifies that the pandemic period is past, and the **post-pandemic period** is in effect, the Influenza Pandemic Policies and associated COVID-19 policies if applicable, will continue to be adhered to throughout the organization;
12. Upon entering the post-pandemic period, the "Influenza & COVID-19 Pandemic Response Command Team" or OMT will continue to provide direction for us as an organization, towards **resuming baseline operation, re-connecting with the broader resident/client community, and addressing any after effects** on staff, clients/residents, and the organization as a whole stemming from the influenza pandemic experience. The regular management structure will resume its command and direction role as soon as is feasible thereafter.
13. For purpose of organizational learning, a **comprehensive post influenza pandemic incident review** is to be conducted as soon as possible in the post-pandemic period to improve the readiness of the home in managing future challenges.
14. The IPAC Lead and supported by Corporate Consultants (if applicable) with the Influenza & COVID-19 Pandemic Response Command Team or OMT, will conduct with such other staff as might be necessary, an **annual table-top exercise to simulate responding to a pandemic flu outbreak** to:
    - Ensure awareness and familiarity with the policies and procedures.
    - Test specific aspects of the plan
    - Review and distribute results to all key individuals – e.g. external stakeholders such as the local PHU – and participating groups.

PANDEMIC RESPONSE

SURVEILLANCE,
REPORTING,
AND
COMMUNICATION

PURPOSE:

Surveillance and Reporting

Surveillance is an essential component of any effective infection prevention and control program. *For pandemic flu & COVID-19(if applicable), management purposes, the goal is to ensure identification of potential or actual outbreak in its early stages so that control measures can be instituted as soon as possible to protect clients/residents and staff at the home*.
Health services providers are expected to keep local (public) health units i.e. PHU(s) apprised of all suspected outbreaks, and to cooperate with local system community response plans during an outbreak. In turn, it is expected that the PHU(s) will report outbreaks to the Public Health Division – Infectious Diseases Branch of the Ministry of Health and Long-Term Care (MOHLTC) for higher-level directives.

Communication

In the event of a flu or COVID -19 pandemic, it is essential that clear, accurate, and consistent communication be maintained, both:

- *Internally*, with
  - Board of Directors (if applicable), Residents, Family members and Consultants (if applicable)
  - Staff, and volunteers
  - Affiliated service-providers to the home i.e. physicians, rehabilitation therapists, and other health services providers
  - Students undergoing training at the home, and

- *Externally*, with
  - Government Agencies i.e. MOHLTC, and PHU(s)
  - Other health/social services providers e.g. local hospitals, other long-term care homes, Ontario Health Teams, and community support services agencies
  - Partner organizations e.g. universities, training programs,
  - Contractors, goods and services suppliers
  - News media, and
  - Community at large

During a pandemic flu or COVID-19 outbreak, people will be exposed, through various sources, to information and rumours about the spread and virility of the virus, which will fluctuate according to prevailing circumstances.

It is important that we, as an organization:

- Demonstrates both awareness of the potential for a pandemic, and capability to manage it;
- Maintains vigilance in surveillance/reporting of potential/actual pandemic flu or COVID-19 outbreaks;
- Coordinates information flow with the appropriate authorities;
- Communicates a business continuation plan; and,
- Provides clear, timely, and proactive advice to all stakeholders as events unfold

Communication, for the purpose of this policy, includes:

- Reporting to government to support health system surveillance integral to local and provincial pandemic plans;
- Managing information for purpose of providing essential care, support, and reassurance to clients/residents
- Supporting staff and affiliated services providers by meeting their need for accurate information; and,
- Informing clients/residents, their families, and the public where appropriate and necessary

POLICY

1 Surveillance and Reporting

Normally, we will

1.1 Monitor flu or COVID-19 outbreak indicators as per established policies and procedures for baseline-infection-control practice and as directed by Ministry of Health Long Term Care, FLTCA, 2021 and the local Public Health Unit.

1.2 Have an internal reporting protocol for staff to notify infection control practitioners 24 hours a day, 7 days a week, if an outbreak is suspected.

1.3 Have an external reporting protocol for each facility to notify the corresponding Public Health Unit 24 hours a day, 7 days a week, if an outbreak is suspected.

1.4 Regularly review and reinforce practice of such a protocol with all staff.

In the event of heightened alert level during the Inter-pandemic Period, and during the Pandemic Period, we will

1.5 Switch to monitoring of such other indicators as might be specific to an anticipated pandemic flu or COVID-19 outbreak issued by the World Health Organization and local Public Health Unit.

1.6 Participate in local health system communication/liaison forums to keep apprised of risks, warning signs, and progresses associated with anticipated/actual pandemic flu or COVID-19 outbreaks.

2. Activation of Influenza & COVID-19 Pandemic Plan

We have specific protocol for activating control, staff deployment, communication, and other elements of a business continuation plan in response to an influenza or COVID-19 pandemic.

3. Communication

3.1 This Influenza Pandemic Policy supplements home's policy – *Communication with News Media*, and addresses releasing of information and making announcement to the news media and other parties of interest. It is designed to ensure useful, consistent, and clear flow of accurate information during an influenza pandemic.

3.2 To ensure useful, consistent, and clear flow of accurate information in the context of Influenza or COVID-19 Pandemic Response:

3.2.1 A centralized communication protocol will coordinate all communication activities associated with pandemic flu response undertaken across the home.

3.2.2 A current listing of tenants and other users of the premises will be maintained to facilitate communication.

3.2.3 Designated members of an "Influenza & COVID-19 Pandemic Response Command Team" or OMT will manage communication with external parties such as government agencies, other health care organizations, the news media, and the broader community.

3.2.4 Specific communication channels will be established within the home organization to provide timely and relevant information during an influenza or COVID-19 pandemic to internal stakeholders.

3.3 The Home's Privacy Policies apply in matters of communication regarding identifiable personal and personal health information even during a flu or COVID-19 pandemic, except when privacy policy parameters for specific acts of information collection and disclosure are explicitly waived, and when so instructed to by the government, for the purpose of protecting the health and safety of stakeholders, and the interest/benefit of the wider community.

3.4 All employees, affiliated service providers, and volunteers are informed of their expected and/or alternate roles/responsibilities in the event of an influenza or COVID-19 pandemic.

PROCEDURES

1. Surveillance and Reporting

1.1 Until such time as a pandemic flu or COVID-19 outbreak is declared, or if heightening alert is advised by the local Public Health Unit during the Inter-pandemic Period, existing infection control policies apply.

1.1 When advised to by the local Public Health Unit to enact Influenza Pandemic Response Policies and/or other extraordinary anticipatory surveillance measures, the IPAC lead in collaboration with the Administrator or designate will inform staff as to specific flu or COVID-19 outbreak indicators to monitor for surveillance purposes.

1.2 Responsibility for linkage with external information sources

During the Inter-Pandemic Period, individual managers participating in external forums concerned with Pandemic Flu preparation will monitor system wide pandemic alert level and other relevant information, and report to Senior Management of the home to facilitate response planning and readiness review.

1.3 Responsibility for internal surveillance

1.3.1 The designated IPAC Lead is responsible for surveillance and outbreak management activities as per infection control policies.

1.3.2 In the absence of the IPAC Lead, including during weekends and holiday periods, the Director of Resident Care or his/her designate will be responsible for these functions.

1.4 Target Groups for Surveillance

Surveillance extends to: clients/residents; staff, students and volunteers; as well as families of clients/residents, and other visitors to the premises.

1.4.1 LTCH resident's surveillance and reporting

Continuous surveillance will establish baseline levels of infection throughout the year. Infection rates above the baseline will be taken as indicative of a seasonal influenza or COVID-19 outbreak or the arrival of the pandemic strain.

1.4.1.1 The surveillance program will be enhanced when influenza or COVID-19 activity is reported in the community, and when specific instructions are issued by local Public Health Unit. The home will increase surveillance protocols at their discretion, mitigating the risk of infection with the needs of the residents.

1.4.1.2 The surveillance program will include:

- Strategies that reflect community disease prevalence and the unique epidemiology of infection in long-term care.
- Such measures as are already addressed in existing infection control policies, including but not limited to:
  - Screening of all new admissions in accordance with general infection control principles
  - Ongoing assessment of residents for signs and symptoms for acute infection cluster(s).
  - Monitoring for outbreaks during off peak activity time periods (e.g., weekends, holidays).
  - Implementation of COVID-19 specific protocols and surveillance practices as indicated.
- Identifying sentinel events and trends.
- Analysis of surveillance data by the IPAC Lead which will be used to trigger actions to reduce or eliminate disease transmission.
- Implementing such other specific directives if/when required and available from local PHU(s), MOHLTC, senior management or Head Office Consultants.

1.4.1.3 All direct care staff will be aware of the symptoms of respiratory illness, the criteria for a suspected and confirmed outbreak, and the procedures for reporting to the ICP.

1.4.1.4 Whenever there are clusters (as defined by the local PHU) of acute respiratory tract illness within 48 hours on a LTCH resident care unit, an "outbreak alert" is triggered and tests will be done to determine the causative organism as appropriate. (Note: During an influenza or COVID-19 pandemic, lab testing through accustomed channels to confirm a diagnosis might not be feasible. In that event, the OHPIP section on Laboratory Services is to be referenced.)

1.4.2 Staff, support workers, student and volunteer surveillance and reporting

1.4.2.1 Acute infection clusters among staff, support workers, students and volunteers are screened for throughout the year.

1.4.2.2 Staff, support workers, students, volunteers

- Are made aware of early signs and symptoms of acute infections suggestive of influenza
- Ill with such acute infections is not to come into work. Appropriate attendance management policy is in place to support this expectation.

This rule may be amended during a pandemic when infection is pervasive in the community, and the need for care providers to dependent clients/residents is desperate.

1.4.2.3 Staff, support workers, students and volunteers are expected to report acute infections to their supervisor, who will inform the IPAC Lead, and Occupational Health & Safety (OHS) Manager (if applicable) of cases/clusters of employees/contract staff/volunteers who are absent from work for 72 hours with acute infections.

1.4.2.4 The IPAC Lead

- Will provide advice to the Influenza & COVID-19 Pandemic Response Command Team or OMT during the Pandemic Period.
- Will, in conjunction with the OHS Manager (if applicable),
  - Monitor impact of a pandemic flu outbreak on staff;
  - Assist with developing and delivering education, information, and training for staff as necessary; and.
  - Report to the Workers Safety and Insurance Board (WSIB) as appropriate

1.4.2.5 External Reporting of acute infections

The IPAC Lead will report clusters of acute infections in staff, support workers, students, or volunteers to the PHU, and alert the OHS Manager (if applicable) to any possible break in infection control procedures and occupational risk to workers. Staff involved with infection control and OHS will work together to protect worker health and safety in the context of a pandemic flu or COVID-19 outbreak.

1.5.3.6 Internal Reporting requirements for acute infections include:

- Staff, students, or volunteers reporting their condition, through their supervisor, to the IPAC Lead, OHS Manager (if applicable) or delegate. In the event of a COVID-19 outbreak, surveillance and testing will be required for all persons entering the home except for those exempted as defined in the most up to date Ministry of Health Long Term Care directive.
- Volunteers reporting through Activity Coordinator to the IPAC Lead.

- IPAC Lead alerting the OHS Manager (if applicable) about any clusters of acute infections in clients/residents so that the OHS Manager (if applicable) can monitor potential impact on staff.
- IPAC Lead alerting the OHS Manager (if applicable) about any clusters of acute infections in staff and volunteers so the OHS Manager (if applicable) can monitor impact.
- As employer, reporting to the Joint Health and Safety Committee any occupationally acquired acute infection.
- Reporting, any occupationally acquired infection to the Ministry of Labour (for investigation) and to the WSIB within 72 hours.

1.4.3 Family members, visitor's surveillance, and reporting

- Instructions are posted for anyone entering or carrying on activities on the premises – e.g. family members and friends of clients/residents, contractors – to self-screen for symptoms of acute infections each time they enter. In the event of a COVID-19 outbreak, surveillance and testing will be required for all persons entering the home except for those exempted as defined in the most up to date Ministry of Health Long Term Care directive.

1.4.3.1

Signs and hand hygiene stations are located at all entrances instructing all visitors to: perform hand hygiene, self-screen for symptoms of acute infections (e.g. new cough, new shortness of breath, fever), and not enter if they have such symptoms. Third party screening will be present in the event of a COVID-19 outbreak.

1.4.3.2 Signs are posted asking all family members and visitors to sign in and out, so that a record is maintained of who has been in a facility in the event of an outbreak.

1.5 The IPAC Lead will report any potential or declared acute infection outbreak, internally and externally, in accordance with existing Infection Control Policies.

2. <u>Activation of Influenza Pandemic Policies</u>

2.1 Notification received by the IPAC Lead in conjunction with the Administrator or designate, from the relevant government agency – usually a PHU – is the trigger event for activating the Influenza Pandemic Policies mandated procedures targeting the Pandemic Period.

2.2 Normally, only the Administrator is empowered to activate these procedures. If s/he is unavailable when the flu or COVID-19 pandemic is declared, a designated alternate in order of the cascade described below is authorized to activate these policies.

Cascade of Officers authorized to activate the Influenza Pandemic Policies

Primary	Administrator
First Alternate	IPAC Lead
Second Alternate	Director of Care/Acting Director of Care

2.3 The Influenza & COVID-19 Pandemic Response Command Team (IPRCT) or Outbreak Management Team (OMT)

2.3.1 Team composition

A pre-identified IPRCT or OMT, comprised of managers with key responsibilities, will form a cabinet to assist the IPAC Lead in conjunction with the Administrator or the designated alternate, in managing operations of the home during the Pandemic Period.

Influenza Pandemic Response Command Team or Outbreak Management Team

Role	Scope of Responsibility
IPAC Lead & Administrator	1. Liase with Head Office Consultants (if applicable) to ensure corporate and facility strategic decisions regarding all aspects of operations, including but not limited to: ▪ Curtailing service scope and level; ▪ Re-deploying staff and other resources. 2. Liaise with government departments/agencies other than Local PHU(s). 3. Serve as spokesperson with respect to: ▪ The News Media; and, ▪ The Community at Large. 4. Authorize cessation of Influenza Pandemic Response Policies implementation, once the Post-pandemic Period is declared by the appropriate government authority.
IPAC Lead	1. Liaise with the local PHU. 2. Liaise with local health & social services as necessary. 3. Manage operation of each centre during the Pandemic Period
Medical Advisory Physician	1. Maintain contact with centre medical directors, and physicians throughout the Pandemic Period. 2. Manage, in consultation with the Coordinators for Local Centre Operations, essential medical coverage for essential service programs during the Pandemic Period. 3. Liaise with such external medical practitioners as might be necessary during the Pandemic Period. 4. Assist the Officer in Command, and Coordinator for Pandemic Intelligence and Planning, with respect to: • Keeping pace with and interpreting emerging medical information through the Pandemic Period; • Reassuring internal and external stakeholders 5. Assist Coordinators for Local Centre Operation in consulting with local PHU(s) and other relevant health services.
IPAC Lead	1. Monitor and compile information available from government departments/agencies, and other credible sources (e.g. WHO) during the Pandemic Period. 2. Develop the most credible intelligence on the status of the pandemic flu outbreak, community response, and advice the Officer in Command on continued strategizing, and composition of communiqué to stakeholders.
Head Office +/or Administrative Office	1. Coordinate arrangements to optimize organizational capacity for continued operation as prescribed in the Business Continuation Policy

– Finance & Information System	2. Maintain communication with contractors, and suppliers of essential goods and services, during the Pandemic Period to secure the best availability of such resources to the home to sustain operation of essential service programs. 3. Optimize telecommunication and information system operation at the home during the Pandemic Period.
Project Manager +/or Administrator – Human Resource Mobilization	1. Coordinate implementation of the Human Resource and Staff Deployment Policy 2. Coordinate with universities, colleges, and other training programs to manage practicum students as a resource during the Pandemic Period. 3. Coordinate volunteers as might be available to supplement staff resources required to maintain essential the home services.
Office Manager/MDS RAI Coordinator Recorder	1. Design/Refine a documentary system, during the Inter-pandemic Period, for record organizational decisions, and major actions taken to sustain the home operations during the Pandemic Period. 2. Oversee daily entry of information into documentary system during the Pandemic Period. Facilitate after-event review and quality improvement initiatives in the Post-pandemic Period as per direction of CEO.
Officer at Large **Corporate Consultants**	1. Provide advice to the Officer in Command. 2. Support other IPRCT members where specific assistance is required. Undertake such previously unspecified role(s) as might arise, at the designation of the Officer in Command.

2.3.2 When a designated primary manager is unavailable or unable, to continue to perform an IPRCT or OMT role, an alternate manager will be mobilized to do so. The cascades of primary/alternate IPRCT or OMT members are listed as follows:

Influenza Pandemic Response Command Team or Outbreak Management Team

Role	Cascade of Officers to Assume Designated Roles
Officer in Command	▪ IPAC Lead in conjunction with Administrator (Primary) ▪ Director of Resident Care (1st alternate) ▪ Acting Director of Care (2nd alternate)
Coordinator – Medical Services	▪ Medical Director – The home Centre (Primary) ▪ Medical Officer of Health (1st alternate)
Coordinator – Pandemic Intelligence and Planning	▪ IPAC Lead (Primary) ▪ Director of Care (1st alternate) ▪ Acting Director of Resident Care (2nd alternate)
Coordinator – Finance & Information System	▪ Chief Finance Officer (Primary) ▪ Manager, Accounting (1st alternate)
Coordinator – Human Resource Mobilization	▪ Project Manager +/or Administrator (Primary) ▪ MDS RAI Coordinator (1st alternate)
Recorder	• MDS RAI Coordinator (Primary) • Office Manager (1st alternate)
Officers at large	▪ IPAC Lead

2.3.3 Other Ad Hoc IPRCT or OMT members will be appointed to replace those who succumb to the flu or COVID-19 during the Pandemic Period, and as need for further assistance to the IPRCT arises.

2.3.4 During the Inter-pandemic Period, the Primary and Alternates for each described IPRCT or OMT role will have conferred and devised a basic operating plan by which to discharge their assigned functions once a pandemic flu or COVID-19 outbreak is declared.

2.3.5 Convening the IPRCT or OMT

The IPRCT Team will be activated at the call of the IPAC Lead in conjunction with the Administrator, or designated Alternate, once a pandemic flu or COVID-19 outbreak is declared by the local PHU, presumably in response to the World Health Organization doing so.

2.3.5.1 IPRCT or OMT members will be summoned via all communications means available to report to the Officer in Command. *A teleconference with the Officer in Command and as many IPRCT or OMT members as can be reached will be convened ASAP initiate appropriate procedures* contained in policies

2.3.5.2 During the Inter-pandemic Period, the Project Manager and Office Manager will have prepared and kept current staff contact lists. These will be made available to other IPRCT or OMT members with which to call in such staff as might be necessary upon activation of the Influenza Pandemic Response Policies by the Officer in Command.

2.3.5.3 IPRCT or OMT members will utilize such lists to call in such staff as is necessary in each of the area for which they are responsible, in accordance with provisions of the Pandemic (Flu) Policies – Business Continuation Plan, and Human Resource and Staff Deployment.

2.3.5.4 Having been convened, among the first orders of business, the IPRCT or OMT will develop and issue, as quickly as possible, a concise and clear announcement about the Pandemic Period having been declared and the home Influenza Pandemic Response Policies being activated both to inform and to reassure internal stakeholders.

2.4 A Centralized-Coordinated Influenza Pandemic Response

2.4.1 A virtual command centre may be required:

2.4.1.1 Requirement for local decision making, and the desirability of dispersing the IPRCT or OMT to minimize risk of multiple key managers being exposed to the same risk of infection, dictates for the IPRCT or OMT to operate, scattered. Gatherings in face-to-face meeting will be kept to a minimum.

2.4.1.2 Most IPRCT or OMT members will operate from their own local centre offices as bases of operation. Some exceptions will be necessary to protect role succession viability:

2.4.2 Centralized-Coordinated command using telecommunication technology

The IPAC Lead will coordinate actions and maintain ongoing and regular contact with the virtual Command Centre (if applicable) using available telecommunication channel(s).

2.4.2.1 Dedicated IPRCT or OMT teleconference code may be considered

The Administrator may pre-designate a *dedicated conference call code* with which the IPRCT or OMT will conduct regular and urgent teleconferences during the Pandemic Period.

2.4.2.2 E-mail

For as long as is available, the internal e-mail system will continue to be utilized. A specific e-mail *Subject Tagline* will be pre-designated for exclusive communication use among the IPRCT or OMT during the Pandemic Period to signify communication concerning specifically related business.

2.4.2.3 Regular telephone line, teleconferencing and web-based meeting forums such as Zoom, Team Meetings etc.

2.4.2.3.1 Use of regular telephone lines will continue to be relied upon for as long as they remain operational throughout the Pandemic Period.

2.4.2.3.2 The IPRCT or OMT, initiated by the IPAC lead will teleconference daily through one of the communication vehicles listed above and provide updates on the operational status of key functional area (e.g., human resource availability, essential supplies inventory, incidence morbidity and mortality rates), and to review and implement required directives as indicated.

2.5 The IPAC Lead in conjunction with the Administrator is responsible for de-commissioning the IPRCT or OMT and deactivating the Influenza Pandemic Response Policies at a suitable time, after the government and local PHU(s) have declared the Pandemic Period to conclude and that a Post-pandemic Period is in effect, and instructions for the home to resume baseline operating and management practices.

3. Communication

2.1 Activating External Linkages as The Pandemic Period is Declared

2.1.1 Establishing linkage with government departments and agencies other than local PHU(s)

2.1.1.1 The IPAC Lead in conjunction with the Administrator will contact the appropriate contact government and other public officials to identify him/herself as the designated coordinator of communication for the home for the duration of the Pandemic Period.

2.1.1.2 Other staff already involved with community forums concerned with pandemic flu or COVID-19 response preparation and liaison will maintain such contacts, and channel information available to the IPAC Lead where required.

2.1.2 Establishing linkage with Local PHU(s)

Upon activation of the IPRCT or OMT, the IPAC Lead will contact the local PHU to identify themselves as the authorized home representative, for purposes of communication as regards the pandemic.

2.1.3 Establishing linkage with other Key External Contacts

2.1.3.1 The IPAC Lead in conjunction with Departmental Managers will contact relevant local partner organizations, and external stakeholders e.g. hospitals, to identify themselves as the contact persons on behalf of the home for purposes of local communication during the Pandemic Period.

2.1.3.2 The Administrator and Head Office Consultants will contact contractors and suppliers, of essential services and material, to activate pre-established supply chain arrangements, if any, and negotiate for others to ensure continued delivery of such goods and services as might be feasible during the Pandemic Period.

2.2 External communication protocol

2.2.1 The IPAC Lead in conjunction with the Administrator will consult with IPRCT or OMT members as necessary to decide on specific information to be released to relevant external parties.

2.2.2 To ensure information about operations, pandemic management, and health status of the home clients/residents is accurately/consistently communicated to external stakeholders with legitimate interest, specific Communication Leads are designated for respective stakeholder groups.

See Procedure 2.3.2 above for the specific IPRCT or OMT member designated to liaise, communicate, and coordinate with each category of external stakeholders, and their intended alternates.

2.2.3 To inform and reassure external stakeholders and the community at large about the status of a pandemic flu or COVID-19 outbreak and the home's response:

2.2.3.1 A specific location on the home Website will have been pre-designated as one channel by which to broadcast official announcements.

Communication channels are to be activated by the IPAC Lead in conjunction with the Administrator or designate. Only she can approve specific communiqués for posting on these channels.

2.2.4 Communication with News Media

The home Policy on Communication will apply during the Pandemic Period. Essentially, only the Administrator or Alternate, is authorized to speak with the News Media on behalf of the home, including that pertaining to a pandemic flu or COVID-19 outbreak.

2.2.5 Communication with other External Stakeholders

Whence the primary and alternate IPRCT or OMT members responsible for communicating with a category of external stakeholders are no longer available, the Administrator will appoint replacement Alternates.

Where no other IPRCT or OMT member has been pre-designated, the Administrator or delegate will be the authorized speaker on behalf of the home.

2.3 Internal communication protocol

2.3.1 During the Inter-pandemic Period, updates on influenza or COVID-19 pandemic planning at the home will be communicated to all internal stakeholders through such channels as regular General Staff Meetings, the home Communication Book, ad hoc meetings with LTC residents, and such other means as might be deemed appropriate by the Administrator.

2.3.2 During the Pandemic Period, the Administrator will consult with the IPRCT or OMT as necessary and appropriate to prepare up-to-date information on the status of operation across the home for proactive sharing with all internal stakeholders with a view to providing the most timely, comprehensive, and useful information for all concerned.

2.3.3 To ensure information about operations, pandemic flu management, and health status of residents are accurately and consistently communicated to internal stakeholders, constituency specific Communication Leads have been designated. (See Procedure 3.3.4 below)

2.3.4 Designated internal Communication Leads:

Constituencies	Communication Lead	
▪ **LTCH Residents and Staff** ▪ **Affiliated Health Services Providers** ▪ **Students, Volunteers**	▪ Administrator ▪ Director of Care	(Primary) (Alternate)
Corporate Staff	▪ Chief Executive Officer ▪ Chief Operating Officer	(Primary) (Alternate)
Medical Services	▪ Medical Director, and ▪ Alternative Medical Director ▪ Director of Care	(Primary) (Secondary (Alternate)

2.3.5 Official announcements pertaining to a pandemic flu or COVID-19 outbreak, and the operational status of the home

2.3.5.1 Such information will be posted on a pre-established Intranet and voice mailboxes to keep staff and other internal stakeholders informed.

2.3.5.2 Only the Administrator can approve specific communiqués for posting onto and removal from this channel.

2.3.6 In addition to proactive communication on the part of the organization, internal stakeholders can also address specific query to the designated Communication Lead for their area. The latter will provide such information as is available or refer to the Administrator

2.4 This communication plan, once implemented, will stay in effect until the Post-pandemic Period is declared by the relevant authority, and the IPRCT or OMT is disbanded at the instruction of the Administrator.

Note: Portions of this policy has been reproduced or paraphrased from the document *A Guide to Influenza Pandemic Preparedness and Response in Long-Term Care Homes* (2005) produced by the MOHLTC-Emergency Management Unit.

5 Resurrection Rd. Toronto ON M9A5G1
Tel. 416-232-2112 • Fax 416-232-0511

Pandemic Response

Containment
and
Risk Reduction

PURPOSE:

In the event an anticipated or actual influenza or COVID -19 pandemic outbreak is declared by the responsible government agency, {e.g. the Local Public Health Unit (PHU)} a specifically pre-determined Influenza Pandemic Response Plan will be activated to:

- Reduce the risk of the flu or COVID-19 infiltrating for as long as possible, and
- Contain the infection as much as possible if/when residents, employees, and/or affiliates of the home are involved.

These policies and procedures consist of measures to be implemented during both the Inter-pandemic Period, and the Pandemic Period throughout the home to minimize the potential and actual impacts that a flu pandemic might have on the functioning of the organization and on associated constituencies.

These policies address:

1. Preparing staff with knowledge about the pandemic flu or COVID-19, so as to avert/minimize panic responses to an outbreak;
2. Meeting staff need for credible information with which to reassure clients/residents;
3. Maintaining staff awareness and familiarity with infection control procedures relevant to a pandemic outbreak;
4. Putting in place extraordinary measures to keep infection contained and isolated when/where it occurs; and,
5. Reduce the risk of infection to residents in the care and to staff continuing to provide care for them, so that essential services can continue to be delivered during high-risk periods.

POLICY

In order to reduce the risk of flu or COVID-19 and contain infection spread once a pandemic flu or COVID-19 outbreak is in effect,

1. Prophylactic immunization against the annual flu is to be promoted as a baseline measure. Mandatory vaccination protocols for COVID-19 will be enforced.
2. Training in infection control, safe practice, and protective equipment are to be provided for staff to enable their continued performance of client/resident care functions during the Pandemic Period while having the best protection possible against contracting and spreading the pandemic flu or COVID-19. Clients/Residents and their family members will be provided with education/information about the nature of a pandemic flu or COVID-19, what to expect as a service provider, and prudent preparatory measures against the potential impact of a pandemic flu or COVID-19 outbreak.
3. Graduated implementation of containment responses appropriate to the presenting risk of the pandemic flu or COVID-19 spreading over time is to be activated, including:
    - Increasingly stringent Infection control and cleaning procedures, beyond that specified in Infection Control policies when advised or prescribed by the local PHU(s);
    - Specific senior managers being held responsible for maintaining infection control;
    - Cohorting residents and staff to contain local outbreak, and reduce the risk of infection
    - Heightening control of visitor traffic, up to and including stoppage of all but specifically authorized visitors from entering the premises; and

- Restricting access to physical site(s) where necessary.
- Requiring staff to refrain from working in multiple healthcare facilities.
- Following all other directives specific to the outbreak definition as indicated by the Ministry of Health Long Term Care and the local Public Health Unit.

4. Essential/priority services to maintain, and others to curtail during the Pandemic Period as a part of the Influenza Pandemic Response Policy *Business Continuation* to facilitate containment and reduce the risk of the pandemic flu or COVID-19 spreading is to be pre-defined.
5. Priority staff groups for antiviral and vaccination administration in the event of insufficient supplies during the earlier phase of the outbreak will have been established to maintain a level of care necessary to ensure the best survival chances for the greatest number of clients/resident's dependent on essential services. Reference will be made to applicable government policy where possible.
6. Vaccines, antivirals, and other treatment as available will be provided to clients/residents in accordance with availability, sound ethical principles, and the aim of optimizing survival chances. Reference will be made to pre-secured advance directives where available
7. Appropriate internal and external capacities will have been arranged to cope with inevitable resident fatality in the event of a pandemic outbreak.
8. Further extraordinary responsive containment and risk reduction measures to counter unanticipated challenges will be devised as the need presents itself.

PROCEDURES

1. Promoting Immunization Against the Flu or COVID-19

1.1 To staff/Volunteers/students:

1.1.1 Information about flu or COVID-19 risk and the impact of an outbreak on themselves and clients/residents receiving care is profiled each year.

1.1.2 Encouragement for vaccination as protection against the annual flu is promoted to all staff/Volunteers/students prior to the onset of flu season and as required. Review of mandatory COVID-19 vaccination policy is promoted to all staff/Volunteers/students and essential caregivers annually and as needed.

1.1.3 Maintain an annual flu and COVID-19 vaccination record of residents/staff/student/volunteer(s) and essential caregivers to inform deployment decisions in response to a pandemic flu or COVID-19 outbreak.

1.1.4 IPAC Lead will facilitate vaccination promotion do for all groups.

1.2 To clients/residents:

1.2.1 Vaccinations against the annual flu, pneumococcal infection and COVID-19 are promoted and provided each year in conjunction with preventative campaigns launched by the local PHU.

1.2.2 Booster doses of pneumococcal vaccine are given to high risk-residents as appropriate. COVID-19 vaccinations and booster doses are made available to residents who have not received on admission and/or as indicated by local Public Health guidelines.

1.2.3 Proper consent is secured from client/resident, or substitute decision maker before vaccination is given.

2. Educating and Training, Protection, and Role Adaptation during A Pandemic

2.1 Influenza & COVID-19 Pandemic Education

2.1.1 Accurate information about the nature and risks associated with a pandemic flu & COVID-19, and the Influenza Pandemic Response policies and procedures will be provided at orientation for those newly joining the organization as staff, volunteer, or student to establish baseline awareness, annually thereafter and as required. Training & education will also be provided to residents, essential caregivers and visitors at a minimum annually and as required.

2.1.2 Ongoing education will be provided to maintain incumbent staff/volunteer/student/essential caregivers/residents and families as needed with applicable Influenza Pandemic Response policies and procedures.

2.1.3 Once the Influenza Pandemic Response Plan is activated, the IPRCT will assume responsibility for determining information and supplementary training needs required to support staff/volunteers/students in delivering essential services, and arrange for such needs to be met.

2.2 Protection of Staff/Volunteers/Students/Essential Caregivers/Support Workers

2.2.1 Infection control best practice with which to continue working during a Pandemic Period will be reinforced through in-service training initiatives to be implemented in the Inter-pandemic Period.

2.2.2 Appropriate protective equipment, as recommended by relevant government departments, including masks, goggles, gowns, gloves, and others will be stocked as per Policy, and issued to staff requiring their use once a pandemic outbreak is declared

2.2.3 All employees are fit tested, where necessary, for appropriate protective masks, and a record of the recommended fit for everyone is maintained as part of their personnel records in the Human Resources Department. All fit-tested employees are trained to seal test masks upon donning.

2.2.4 Training in donning and removal of personal protective equipment is routinely provided at orientation for staff, annually for all and as required.

2.3 Role Adaptation

2.3.1 Where job role adaptation is required due to constrained human resources availability during a pandemic flu or COVID-19 outbreak, staff/volunteers/students/essential caregivers will be provided with the necessary training to enable continued delivery of essential services.

2.3.2 During the Inter-pandemic Period, managers will develop quick training protocols, and be ready to implement them, to facilitate staff diverted from

other areas to supplement incumbent staff of each functional area depleted during the pandemic flu crisis.

2.3.3 During the Inter-pandemic Period, managers will develop Job action sheets and other training/education material relevant to specific functional roles that might need to be covered by otherwise untrained staff.

3. Enforcing Containment for Infection Control during The Pandemic Period

3.1 Adjusted cleaning and sterilization procedures consistent with extraordinary infection control practice prescribed by local PHU(s) will be activated and sustained through the Pandemic Period.

3.2 The IPAC Lead will supervise implementation of infection control measures and make regular status reports through the Influenza & COVID-19 Pandemic Response Control Team (IPRCT) or OMT during the Pandemic Period.

3.3 Clients/Residents having succumbed to the pandemic flu or COVID-19 will be cared for in their resident care unit of origin, and only cohorted for care in pre-designated resident care area if necessary or in the presence of COVID-19. Where appropriate, care for these residents will be provided by specific cohorts of staff who will only work in such areas to minimize the risk of the infection spreading to other parts of the home.

3.4 The home has space (e.g. lounges, activity rooms) earmarked for temporary conversion to resident care areas for purpose of containment and infection control when necessary. The home has designated isolation rooms.

3.5 Environmental processes to manage containment in the event of a pandemic flu or COVID-19 outbreak will include:

3.5.1 Controlling entrances/exits through use of signage, access cards;

3.5.2 Staffed stations at designated entrances for visitor screening, and access control – including verifying proof of identity of employees, affiliated service providers, volunteers and students; screening visitors for previous attendance at other high infection risk locations prior to visiting, and other means deemed necessary;

3.5.3 Contracting for security personnel services if deemed necessary by the IPRCT or OMT.

3.5.4 Staging test(s) of some or all such controls to restrict access, annually, for continuous quality improvement purposes.

3.6 Managing Personnel and Material Traffic Premises:

3.6.1 The IPAC Lead in conjunction with the Administrator and with the Facility Manager and other management staff will pre-designate movement routes within the facility to manage personnel and material traffic during the Pandemic Period so to minimize risk of cross contamination between areas used to house residents with symptoms suggestive of the pandemic flu and presumably flu free areas.

3.6.2 Internal traffic flow charts have been prepared and stored by Facility Managers ready for posting, and distribution to staff involved with moving of supplies once the Influenza Pandemic Response Plan is activated.

3.6.3 The IPAC Lead in conjunction with the Administrator and their respective management team will develop a logistics plan for managing, during the Pandemic Period:

- Uninterrupted ambulance flow to and from the facility;
- Access and egress control of authorized vehicles carrying supplies and equipment to a dock area;
- Authorized vehicle parking;
- Direction for authorized personnel and visitors to proper entrances;
- Families of residents, and other personnel converging on the facility;
- Anticipated increases in visitors and curious onlookers seeking to gain entrance;
- A waiting area to handle unwarranted access requests, away from the high traffic or contaminated areas, by the relatives and friends of residents; and,
- A plan to discourage visitors from entering the facility during a pandemic (e.g. ways of maintaining communication with residents' families via telephone or other means to provide status reports).

3.6.4 As a principle, to contain infection, and reduce the risk of cross contamination, it is not recommended that staff/volunteers/students be deployed or work in multiple areas, or work for multiple organizations, if possible. This issue is specifically addressed in the Policy

4. Prioritizing of Services/Programs

4.1 To conserve availability of staff resources and to contain infection, operation of specific services/units/programs might be reduced or suspended, and the use of associated space discontinued for the duration of the Pandemic Period. Such decisions will be made by the IPRCT or OMT in collaboration with the IPAC Lead and Administrator.

4.2 Refer to Policy for guidelines by which to priority rank services and programs to maintain or curtail operations during the Pandemic Period.

5. Providing Antivirals and Vaccines to Staff

Once a pandemic flu or COVID-19 outbreak has occurred, access to vaccines may be delayed. In the meantime, it is expected that demand for antivirals, for temporary prophylactic use, might outstrip supply at least during the early phase of the Pandemic Period.

5.1 Priority grouping of staff to be issued antivirals – and vaccinated once a vaccine becomes available – will have been established by using the enumeration tool provided by the local PHU.

5.2 This enumerated list, compiled for each LTCH, is submitted to the local PHU(s) as per their instruction, and kept updated to reflect staffing changes during the Inter-pandemic Period.

5.3 Once supply of antivirals and vaccines are received, the IPRCT or OMT will determine how distribution will be administered in accordance with directives issued by the local PHU(s).

6. Providing Antivirals and Vaccines to Clients/Residents

6.1 The Director of Care, or designate, will ensure that prescriptions for antivirals and pandemic flu or COVID-19 vaccine administration, are secured from attending physicians or the Medical Director, and included in residents' files.

6.2 Consent for administration of antivirals and immunization will be secured from residents or their Substitute Decision Makers (SDM) as appropriate.

6.3 Where an SDM is involved, contact information for each resident's SDM is kept up to date in his/her health record.

6.4 Advance directives, including "Do Not Resuscitate" (DNR) orders, and that related to the effects of a pandemic flu or COVID-19, have been discussed, established, and updated with residents or SDM.

6.5 Where antivirals and vaccines have had to be rationed, the priority ranking established by and related directions issued by the relevant government agency (e.g. the MOHLTC Emergency Management Unit) will be followed as per instruction by the IPRCT.

6.6 Relevant information about priority ranking for provision of antivirals and vaccines to clients/residents followed will be communicated to clients/residents and their families as appropriate through established communication protocol under Policy

7. Coping with Inevitable Client/Resident Fatality

7.1 The Administrator will consult with the local PHU, funeral homes, and other health services partner(s) as might be appropriate to pre-arrange for offsite mortuary capacity, and other means for handling remains of deceased residents, as might be needed during the Pandemic Period.

7.2 Relevant directions by the local PHU and other relevant government agencies in the context of the Pandemic Period will be followed regarding handling of the remains of deceased residents.

7.3 Given that offsite storage of bodies might be limited in availability during such extraordinary times, and that long waiting period before funeral services can pick up is likely, the Administrator will establish with his/her management team internal space and resources at each site that can be converted for use as a mortuary as an absolute last resort.

7.4 When designating internal location to house and preserve deceased clients/residents pending evacuation by appropriate external parties, kitchen equipment/coolers are not to be used for the storage of bodies to avoid cross contamination.

8. Further extraordinary responsive containment and risk reduction measures will be devised by the IPRCT or OMT and other internal staff resources, and implemented, as situation dictates or upon advice by the local PHU(s).

Note: Portions of this policy has been reproduced or paraphrased from the document *A Guide to Influenza Pandemic Preparedness and Response in Long-Term Care Homes* (2005) produced by the MOHLTC-Emergency Management Unit

PANDEMIC RESPONSE

BUSINESS CONTINUATION

PURPOSE:

In the event of a pandemic flu or COVID-19 outbreak, it is expected that:

- o Supply of material resources and services from external sources, needed to sustain operation of services/programs, will be at risk of serious interruption;
- o Complementary community resources in the health and social services sector that support clients/residents during the Inter-pandemic Period might be curtailed;
- o Availability of both professional and support staff might be negatively impacted upon, both directly and indirectly, by people contracting the pandemic flu or COVID-19; and,
- o The need of clients/residents for care/services in general, and in connection with the pandemic flu or COVID-19, will rise dramatically beyond the Inter-pandemic Period baseline level.

Pre-planning and specific pre-arrangements will be required to be able to continue delivering essential services under adverse operational conditions. It is towards this end, that these policies and procedures have been established to define:

- o What constitute essential services/programs that we will strive to continue delivering;
- o What are the conditions under which specific services will be curtailed to conserve and re-deploy scarce human and material resources to sustain such essential services/programs;
- o How critical decisions regarding continuation and curtailment of service/program operation are to be made;
- o What material resources are required to sustain essential services/programs operation;
- o How continued supply and prudent rationing of essential material resources are to be ensured;
- o How scarce material are to be safeguarded from preventable depletion e.g. inadvertent wastage and criminal action precipitated by a desperate community under circumstances of a pandemic outbreak; and,
- o What process changes will have to be enacted to enable the organization to continue functioning without readily available human resources, and material supplies.

POLICY

In the event of a pandemic flu or COVID-19 outbreak, the Business Continuation Plan will include:

1. A pre-defined priority cascade for rationalizing services, when necessary, to conserve resources for sustaining essential programs, in accordance with the principles of:
    - I. Meeting the needs of residents for whom availability of service is critical for their survival.
    - II. Minimizing adverse impact on clients of services/programs that are scaled back or suspended
    - III. Maximizing the utility of available human and material resources as the pandemic flu or COVID-19 outbreak impacts upon the supply chain(s)

IV. Reviewing and adjusting to the evolving need for curtailment during the Pandemic Phase with a view to re-instituting services/programs as soon as safety assurance and resource availability allow.

2. Plans for managing clinical care of a large long-term care home (LTCF) with residents ill from the flu or COVID-19, including designating areas for cohort-location of residents with pandemic flu or COVID-19 symptoms, and cohort-assignment of staff
3. Response protocols for coping with breakdowns in essential non-clinical services, including: restricted supply of clean water; hydro and natural gas failure; waste and garbage disposal; reduced dietary and laundry services
4. An effective system, for purchasing, stock-piling, storing and distributing equipment and supplies across the organization
5. Specific operating procedures for each Department to continue providing pre-defined essential services.
6. A recovery plan to facilitate all departments to return to baseline operations all services/programs in an orderly manner during the Post Pandemic Recovery Phase.

PROCEDURES:

1. Prioritizing and Rationalizing Services/Programs for Continued Operation

1.1 (Essential) Services/Programs – Incumbent Residents/Clients

1.1.1 *Long-Term Care Homes* residents

- Who have healthcare needs requiring substantial amount of clinical services i.e. that provided by physicians, nurses and other healthcare professions normally delivered in a long-term care home setting;
- Who, or whose families, understand and accept that available service might be moderated from their baseline level in order to adapt to resource restrictions during the Pandemic Period;
- Who have no other alternate abode that they can choose to go to, where informal caregivers are available to provide care to them; or,
- Whose families are unable, or choose not, to remove them from the care during the Pandemic Period.

1.1.1.1 Temporary Leave of Absence in the Context of a Pandemic Flu or COVID-19 Outbreak

- Normally, the Ministry of Health and Long-Term Care (MOHLTC) has policies governing the length of time a LTCH resident might go on a leave of absence without jeopardizing their resident status.
- When MOHLTC issues directive for application in the context of a pandemic flu or COVID-19 outbreak, it will be relayed to

residents and applicable SDM to inform their decision over whether the resident will stay over the Pandemic Period.

1.1.1.2 In situations where a resident temporarily leaves the home when pandemic flu or COVID-19 outbreak is declared, and then elects to return during the Pandemic Period,

- Local (Public) Health Services (PHU) guidelines about residents returning from the community to the LTCH, when available, will determine if re-admission during the Pandemic Period will be accommodated.

- Returning residents will be located in accordance to their care need, status of exposure to the flu or COVID-19, and how services are configured at the time. Safety and best interest of both the individual returning resident and that of others being cared for will inform the decision. Returning to their pre-leave of absence floor/unit/room is not guaranteed.

1.2 Ancillary Services/Programs – Incumbent Clients

All other programs/services not described above in Procedure 1.1 will be suspended when the Influenza Pandemic Response Plan is activated. Operation of these programs will remain suspended for the duration of the Pandemic Period:

- *Active Senior Programs*
- *Congregate Dinning Programs*
- *All Adult Day Programs*
- *Caregiver Support (Counseling)*
- *Caregiver Support (Education & Training)*
- *Client Intervention and Assistance*
- *Transportation*
- *Friendly Visiting*
- *Preparation and Supply of food to Community Meals-on-Wheels programs operated by other agencies*
- *Security checks*

Operation of these programs will be suspended to curtail congregating of persons (i.e. to optimize social distancing as an infection control measure) and reduce the risk of infection to both staff and clients.

1.3 Admission/Enrollment into Services/Programs – New Residents/Clients

1.3.1 *Long Term Care Homes*

The IPAC Lead in consultation with the Administrator and the Director of Care and with the IPRCT or OMT, will maintain communication with MOHLTC, and local PHU(s) regarding admission of new residents. It is expected that, individuals previously not residing in the home should not proceed during the Pandemic Period. It is expected that such concerns as risk of infection to incumbent and prospective residents and when individuals are transferred between hospitals, and other environments with varying exposure to the risk of infection will be considered with due care.

1.3.2 *All Other Programs/Services*

As all Level II Services/Programs are to be suspended, no new admission/enrollment into any program/service other than the Home is expected to be processed during the Pandemic Period.

1.4 Decision-making pertaining to curtailment, suspension, continuation, and resumption of Programs/Services

With due reference to afore articulated principles, the IPAC Lead, in consultation with the IPRCT or OMT, will make the best decision possible, taking into consideration all relevant information, available at the time, from external and internal sources about risk of infection spread, availability of resources, and community need, with reference to the principles of:

I. Meeting the needs of residents for whom availability of service is critical for their survival.

II. Minimizing adverse impact on clients of services/programs that are scaled back or suspended.

III. Maximizing the utility of available resources (both human and material) under the confine of the impact of the pandemic flu or COVID-19 outbreak on the supply chain(s).

IV. Reviewing and adjusting to the evolving need for curtailment during the Pandemic Phase with a view to re-instituting services/programs as soon as safety assurance and resource availability allow.

2. <u>Managing Care of LTCH Residents during The Pandemic Period</u>

It is anticipated that a substantial proportion of LTCH residents, whose immune system might already be compromised by other pre-existing health condition(s), will succumb to the pandemic flu or COVID-19. To support containment and minimize the risk of infection spreading:

2.1 Residents diagnosed with the Pandemic Flu or COVID-19, or who show symptoms strongly suggestive of the same, will be relocated and cared for in cohorts in specifically defined areas within the home

2.2 How best to pre-plan for cohorting residents for care in the context of a pandemic flu or COVID-19 outbreak will be managed by the IPAC Lead in consultation with the Director of Care.

2.3 Every effort is to be made to help these residents and their families understand the rationale behind such a policy, and to reassure them that the best care possible will continue to be provided to them.

2.4 Specific local patient care space will have been pre-identified and relevant clinical leads e.g. Medical Director, Director of Resident Care (DRC) etc., to congregate such residents.

2.5 Cohort-assignment of staff to provide care for resident's sick with the pandemic flu or COVID-19 or based on staff themselves recovering or having recovered from the pandemic flu or COVID-19 will be implemented.

2.6 Group activities, programs, and outings into the community, in which residents from multiple areas normally congregate during the Inter-pandemic Period, will be reduced/suspended/cancelled in accordance with level of infection risk identified during the Pandemic Period, and as dictated by the availability of staff to porter and provide programming support and as directed by government legislation relevant to the pandemic and reflective of the most recent Ministry of Health Long Term Care guidelines.

2.7 Admission of new residents and re-admission of incumbent residents returning from hospitals or other environments will be managed in accordance with criteria established in consultation between the relevant authorities (i.e. MOHLTC and local PHU) and the Medical Director, with due consideration being given to containment and risk reduction requirements.

2.8 In the unlikely event where it becomes necessary to evacuate, such will be expedited referencing the emergency evacuation plan that utilizes facilities.

3. Managing Essential Non-Clinical Resources to Enable Continued Operation

Apart from medical and nursing care, therapeutic and activation, and personal support, other non-clinical services/resources are required to enable clients/residents to be cared for during the Pandemic Period.

3.1 Facility Management

3.1.1 Hydro, Natural Gas, Water Supply

3.1.1.1 Planned Response to Hydro and/or Natural Gas Supply Failures

In the Inter-pandemic period, the Environmental Services Supervisor (ESS) will undertake to determine and make recommendations to Senior Management about emergency generator capacity, and alternate fuel resources to explore and secure, in order to ensure that there is reasonable capacity to maintain essential services in critical areas (e.g. patient care areas, kitchen) Provisions already articulated in the home Disaster Manual are to be referenced.

3.1.1.2 Planned Response to Restriction in Water Supply
In the Inter-pandemic period, the ESS will review minimum need for eating, drinking, washing dishes, bathing residents, medical procedures at each centre, and review/explore contracts to receive sterile water, bottled water, hauled water etc. in case of interruption in normal water supply. Provisions already articulated in the Disaster Manual are to be referenced.

3.1.1.3 The Office Manager will check with incumbent suppliers about their pandemic business continuation plan or disaster recovery plan to identify their obligations and commitments to customers in the event of a pandemic flu or COVID-19 outbreak.

3.1.2 Waste and Garbage Disposal

3.1.2.1 In the Inter-pandemic period, the ESS will review minimum requirement for waste and garbage disposal and make recommendations for ways to manage waste/garbage accumulation while awaiting such municipal services to resume should the latter experience a breakdown.

3.1.2.2 As a part of pre-planning, the ESS will ascertain the pandemic readiness plan of municipal services and/or private companies upon whom the home depends for waste and garbage disposal.

3.1.3 Non-critical maintenance work during pandemic

To reduce risk of infection spread by limiting unnecessary people traffic during the Pandemic Period, non-critical maintenance work will generally be suspended, or only restricted to outdoor areas where workers will not come into contact with residents vulnerable to infection.

3.2 Laundry Services

If laundry services are disrupted due to staff shortage, the Director of Care will ensure that nursing and laundry staff develop locally feasible plans for minimizing the accumulation of laundry to be processed without precipitating avoidable risk of harm to residents due to sanitation breakdown in resident living areas.

3.3 Food Services

To compensate for constricted availability of dietary service personnel during the Pandemic Period, staff and volunteers not normally involved in dietary services will be trained and re-deployed under the provisions of Influenza Pandemic Response Policy for *Human Resource and Staff Deployment*, to ensure that residents' dietary needs are met.

3.4 Business Services

Wherever business functions do not require in-person contact, staff should be encouraged to conduct their work activities off site e.g. from home and stay connected to the office via telephone, e-mail, and such other means of contact as might be practicable. The areas involved include:

3.4.1 Human Resources - Payroll, Bank Deposits, and Other Functions

3.4.2 Finance - Accounts Payable and Other Functions

3.4.3 Information Technology

4. Purchasing, stock-piling, storing and distributing equipment/supplies

4.1 Medical Equipment and Related Supplies

4.1.1 With a surge in need, for essential medical equipment and supplies, likely to be precipitated by a pandemic flu or COVID-19 outbreak, and the risk of the supply chain being overwhelmed (at least initially) a real possibility, the home is to maintain a stockpile sufficient to meet resident care requirement for up to 6 weeks.

4.1.2 An inventory of medical equipment and related supplies is to be regularly maintained by the Director of Care. An inventory template (Appendix A), derived from that issued through the OHPIP, is provided as a basis by which the Administrator, and management team is to adapt to suit their requirement as dictated by their resident population profile.

4.1.3 Managers normally responsible for securing medical equipment and related supplies will identify and pre-negotiate contracts, where necessary, with alternative suppliers to ensure availability and delivery of supplies should the normal supply chain be disrupted in the event upheavals precipitated by the outbreak of a flu or COVID-19 pandemic.

- Wherever possible, 24/7 contact number for these suppliers, and their commitment to respond to such urgent appeals should be secured.

- The Chief Finance Officer (if applicable) will coordinate with the Administrator and other managers to negotiate with alternative suppliers for contingency contracts wherever possible in the event that reliability of primary suppliers is adversely affected by the pandemic flu or COVID-19 outbreak.

4.2 Laboratory Services

The Director of Care will project requirement and develop a plan, in accordance with proper infection control protocol, to address prompt and safe transport of specimens to the PHU or private laboratory under contract in the event of a pandemic flu outbreak, including ensuring shipping containers are readily available to transport specimens safely.

Testing supplies necessary for immediate and diagnostic results specific to the flu or COVID-19 will be maintained on site at all times, with an initial 45-day stock pile of Rapid Antigen testing swabs and PCR testing swabs.

4.3 Pharmacy Supplies

Within the limit of feasibility and prudent practice, the Administrator and other managers:

4.3.1 Ensure plan(s) are in place to ensure continued availability of supplies essential to managing the flu or COVID-19 and related disease challenges, including but not limited to:

- Antibiotics;
- Symptom management medications – e.g. Tylenol, Advil…etc.;
- Antivirals and influenza vaccine
- Anti-nauseant drugs
- End of life drugs – injectable narcotics, Haldol, midazolam, atropine, scopolamine
- Hypodermoclysis kits and solution

4.3.2 Depending on locally feasible opportunities, undertake to:

- Pre-contract with pharmacies;
- Pool stockpiling with other LTCH(s), and other supply resources;

4.3.3 The Corporate Staff Group(if applicable) will endeavor to build relationships with health care providing organizations outside of local areas as a means of securing alternate emergency sources of supplies e.g. through Memorandum of Understanding.

4.3.4 Develop plan(s) to address rationing of medications and supplies if necessary.

4.3.5 Plan for how prophylactic antivirals and vaccines for influenza or COVID-19 can be controlled, stored securely and tracked.
The Administrator in conjunction with the Director of Care will appoint a specific staff person(s) to receive, store and track antiviral medications and liaise with the PHU, as per the latter's requirement for a designated contact person once a pandemic flu or COVID-19 outbreak is declared.

4.4 General Supplies

4.4.1 Dietary Supplies

The Food Services Manager (FSM) will consult with the Administrator and ESS to project requirement and feasibility for stockpiling of nonperishable dietary supplies enough to provision for a temporary interruption in availability of dietary supplies for Levels One and Two Priority Program/Services residents for up to one month.

4.4.2 Laundry/Linen/Cleaning Supplies

The ESS, in consultation with the Administrator, will have developed a plan for stockpiling, storage, and provisioning of such material resources as necessary to ensure capacity for maintenance of a sanitary and hygienic environment in the event that normal supply is disrupted by the pandemic flu outbreak.

4.5 Security

Anxiety response in the community in the face of a pandemic is inevitable especially if access to antivirals, vaccines, and other essential resources is constricted even if only temporarily. As such, it is imperative for the home to have plans in place to protect stockpiled and rationed scarce supplies.

Both for purposes of reducing risk of infection spread, and protecting scarce supplies, The Administrator and ESS will undertake to develop measures and operating procedures for the home to control access to and from the premises. These might include:

4.5.1 Reducing the number of restricted ingress and egress points except for emergency evacuation purposes.

4.5.2 Having a process for verifying credentials of prospective employees, volunteers, and other approved visitors through staffed screening stations at a single portal into and out of the home

4.5.3 Ensuring that such a process is implemented as effectively and efficiently as possible to minimize inadvertent stress to both staff managing entrance and those seeking entrance

4.5.4 Procedure for responding to protests and appeals when visitors are denied entry, and the expected role of and access to assistance by the police if local disagreements cannot be resolved, and security of the home personnel and premises is deemed at risk

4.5.5 Understanding and agreement with emergency response personnel, including police, paramedics, fire services about infection control requirements for accessing the home

4.5.6 Procedures for monitoring security of storage areas and responding to breaches when identified

4.5.7 Considering if/when retaining of private security personnel services will be deemed necessary.

5.0 *Departmental Operations* - Determining Minimum Operational Requirement

5.0.1 During the Inter-pandemic Period, the Departmental Manager will undertake planning to determine the *absolute minimum staffing complement* necessary to maintain essential services in meeting basic needs of clients/residents in their care.

5.0.2 This minimum operational threshold for all departments will be reported through their normal channel of reporting to the Administrator for review and endorsement. This information will be maintained by the Administrator and updated annually at the advice of the IPAC Lead and Managers.

5.0.3 Each Departmental Manager will review this threshold annually and submit recommendations for adjustments, if any.

5.0.4 Each Departmental Manager will review and establish work roles in his/her area that can be discharged with staff working off site – e.g. from home – in the event of a protracted period when maximum social distancing is to be practiced for the sake of infection control.

5.0.5 When the Influenza Pandemic Response Plan is activated at the home, the IPAC Lead in conjunction with the Administrator will ensure the minimum operations requirement applicable for each Priority Level Program/Service is communicated to the manager involved, and human resources (if applicable).

5.1 Risk Management and Legal Liability

5.1.1 The Chief Finance Officer (CFO) will research and report through the CEO to the home Board of Directors +/or Administrator about insurance availability, affordability, and feasibility for operating in the context of a pandemic flu or COVID-19 outbreak, and take such action as deemed necessary by the Board.

5.1.2 The CFO will review this issue periodically as practice in the long-term care sector and insurance industry evolves and more information to guide future decision in this matter becomes available and present such revised recommendation to the Board of Directors as might be necessary.

5. Operational Recovery Plan during Post Pandemic Recovery Phase

While it is desirable to return to normal operational mode as soon as possible after the Pandemic Period is over, it is expected that human resources at all levels of the organization will have been impacted upon during the outbreak, and it will take some time before the Inter-pandemic Period level of staffing can be available.

6.1 Post Pandemic Period Management and Leadership

Subject to determination by the IPRCT or OMT as to the availability and capacity of the incumbent senior managers to resume their normal responsibilities, the IPRCT Officer in Command might choose to maintain operations of the IPRCT or OMT through the initial phase of the Post Pandemic Period.

6.2 Post Pandemic Period Operations

Subject to determination by the IPRCT or OMT as to the availability of human resources and material supplies, individual department might be directed to continue to operate at the minimum operational threshold level through the initial phase of the Post Pandemic Period.

6.3 Resumption of Inter-pandemic Level of Operation

The underlying aim is to return the organization to the inter-pandemic mode of operations as soon as is feasible, subject to availability of necessary resources.
The IPRCT or OMT, if remaining in operation initially, will consult about readiness of each part of the organization to resume normal operation at least on a bi-weekly basis until the home came revert to pre-pandemic operations.

6.4 After Action Review and Continuous Quality Improvement

6.4.1 The Continuous Quality Improvement Lead (CQIL) or alternate is responsible for documenting the coping effort of the organization through the Pandemic Period. They are responsible for overseeing the organization and storage of such logs and other documentation as will inform an after-action review for purposes of organizational learning and quality improvement.

6.4.2 The Administrator, in consultation with the CQIL, will determine when a full review process is to be undertaken with due consideration given to the need of staff at all levels for relief and recovery from the stress and fatigue immediately after having worked through the difficult crisis of a pandemic flu or COVID-19 outbreak.

6.4.3 A full review report, detailing how the organization has responded to the crisis of a pandemic influenza outbreak, and lessons learnt for future reference, will be part of the CQI plan for the home and communicated to Resident Council, Family Council (if applicable) and posted on the home website as part of the CQI program as defined in the FLTCA, 2021.

6.5 Post Pandemic Period Support for Residents/Clients, Staff, and Volunteers

6.5.1 Resident and Family Support Program

6.5.1.1 As much as available staff resource allow, support for residents and their families should be provided, during the Pandemic Period, as they strive to cope with the anxiety and stress over the threat of infection, the trauma of symptoms, and the loss of fellow residents who succumb to the pandemic flu or COVID-19.

6.5.1.2 Specific opportunity to provide grief and bereavement counseling-based support to residents should also be made available to

address Post Trauma Stress Syndrome like issues in the Post Pandemic Period.

6.5.1.3 While all caring professions will have capacity to engage in such work, it is recommended that those with social work training, and who are not heavily relied upon to provide physical care to residents, be mobilized to form the nuclei of “Resident and Family Support Teams” if possible.

6.5.2 Staff and Volunteer/Student Support Program

As much as staff and volunteers/students are relied upon to provide needed care for residents during the Pandemic Period, they are also most subject to the stress and trauma of repeatedly witnessing suffering and loss of lives during their performing their duties.

While specific support and recognition for the extraordinary efforts of staff and volunteers/students, the home, where possible, will earmark resources, to access critical incident stress debriefing programs, group/individual counseling services, and other forms of employee assistance programs/services for the most valuable of The home resources – their staff and volunteers/students.

Appendix A

MOHLTC Supplies and Equipment Template: Care in the Home

Quantities of supplies for Long Term Care Homes should be calculated based on the formula of 25 staff encounters/resident/day x 31 days a month.

Category	Item	# Required
Hand Hygiene	Liquid Soap Hand antiseptics Paper towels	
Personal Protective Equipment	Surgical/ Procedure Masks/N95 Masks Sharps disposal bins Isolation, paper gowns or resuable(small, medium, large, XL, XXL) Latex Exam Gloves (small, medium, large, XL, XXL) Non-latex Gloves (S, M, L, XL) Safety Glasses, Face shields/goggles	
Temperature & BP monitoring supplies	Thermometers (and disposable covers) Stethoscopes Blood Pressure Cuffs (Child, Adult, Large Adult sizes)	
Disinfectants	Disinfecting Wipes Surface cleaner and disinfectant	
Cleaning	Garbage bags - clear 20x20 for individual stations Garbage bags Autoclave and other specialized waste disposal bags Biohazard bags/boxes and contracted services Mops and pals	

	One-use tissues
Respiratory Care	Oxygen tubing Oxygen masks -- high concentration masks (non-rebreathers) Nasal prongs/cannula Oxygen masks -- low oxygen concentration (Simple O2 masks, Venturi masks Oxymeters and probes Portable oxygen tanks with regulators Portable oxygen, compressor unit Ventilator supplies
Suction	Disposable tips, catheters, tubing, canisters Disposable manual resuscitators (BVM) & filters (various sizes) Inline suction catheters Portable suction
Diagnostic agents	Nasopharyngeal swab specimen kits
X-Ray equipment	Portable unit or contracted service
Dressing supplies for vaccine injection	
Ice Packs	Cold Pack sodium or ammonium nitrate Gel pack soft cold pack
Paper Products	Paper square absorbent table cover Toilet papers
Cots/Mats/Stretchers	
IV Products	Solutions Tubing Pumps Poles
Wheelchairs	
Resident Identification	Identification bracelets
Deceased body management	Body bags/Mortuary kits
Other equipment to be further identified	

Adapted from: Ontario Health Plan for an Influenza Pandemic (OHPIP) June 2005

Note: Portions of this policy has been reproduced or paraphrased from the document *A Guide to Influenza Pandemic Preparedness and Response in Long-Term Care Homes* (2005) produced by the MOHLTC-Emergency Management Unit

PANDEMIC RESPONSE

HUMAN RESOURCES
AND
STAFF DEPLOYMENT

PURPOSE:

Planning to Address Inevitable Health Care Personnel Shortages during an Influenza Pandemic:

Health care providers are no less susceptible to infection than clients/residents in their care during a pandemic flu outbreak,

- A large number of home staff will also fall ill;
- Their families falling ill will require their care; and,
- Other related complicating factors might precipitate hesitancy to report to work.

There will likely be insufficient staff available to continue operating the home at normal operational levels. *Human Resources and Staff Deployment*, focuses on how human resources is to be managed to sustain service delivery during the Pandemic Period to resident's dependent upon the care provided by the home.

Reinforcing the Commitment of the home and Staff as Health Care Providers:

Large numbers of seniors are dependent upon the home for residential care and community support services. As an organization, the home is committed to providing essential healthcare services during a pandemic flu or COVID-19 outbreak. Employees of the home are obligated, both as a part of a senior's care organization, and by the ethical standards of professional colleges, to continue caring for clients even if their own well-being might be placed at risk when doing so.

These policies and procedures articulate the commitment of the home, in the context of an influenza or COVID-19 pandemic, to:

(viii) Sustain a culture of safety within the organization;

(ix) Create a work environment that supports the continued delivery of care/service;

(x) Translate ethical principles into action that considers professional codes of conduct and community values when deploying staff to deliver essential services; and,

(xi) Ensure delivery of the best possible care to clients of essential service programs.

Policy

In the event of a pandemic flu or COVID-19 outbreak, specific human resources management and staff deployment measures will be implemented to mobilize the largest possible complement of human resources available to sustain service delivery, including:

1. *Adjusting levels of programs/services in operation*

   The home will provide as much essential healthcare services, and for as long, as possible during the Pandemic Period to those residents who depend upon the home for care.

1.1 The home will make optimal use of available incumbent human resources, including staff, volunteers, essential caregivers and practicum students to maintain availability of essential services.

1.2 The home will explore and incorporate atypical but appropriate external community human resources to supplement incumbent human resources available to it.

2. *Redeploying available human resources to sustain service delivery*

2.1 The Influenza & COVID-19 Pandemic Response Command Team (IPRCT) or Outbreak Management Team (OMT) – will assume responsibility for coordinating human resources and staff deployment once the home Influenza Pandemic Response Plan is activated.

2.2 The Master Schedule(s) – of all areas will be reviewed and adjusted as necessary to address staffing shortages across all departments and divisions to ensure essential service coverage.

2.3 All Staff, placement students, and volunteers will be mobilized – to assume flexible functions in providing essential care to our clients/residents during this time of crisis.

2.4 Health care workers' duty to provide care – is interpreted as an inherent ethical expectation for all the home employees to continue providing services to dependent clients/residents in the event of a pandemic flu or COVID-19 outbreak.

2.5 Specific guideline(s) to address issues of staff working at multiple sites, and/or for multiple employers – will be put into place and all associated directives received from the Ministry of Health Long Term Care, Ministry of Labor and local Public Health Unit specific to staffing deployment and/or restrictions will be followed and shared with staff, support workers, student placements and volunteers if applicable.

3. *Protecting and supporting employees*

As an employer of choice, the home,

3.1 Acknowledges a duty of care as employer to protect employees exposed to risks while performing their work role

3.2 Is committed to providing employees with appropriate protection against infection while expecting for them to continue working through the Pandemic Period

3.3 Acknowledges the commitment of employees to their duties when working in high-risk situations during the Pandemic Period

3.4 Attends to staff well-being, by addressing the need to balance work and family demands when scheduling work shifts, and helping them address psychosocial concerns associated with working during a pandemic flu outbreak

4. *Pre-establishing minimum staffing thresholds for all functional areas across the home to facilitate human resources deployment during the Pandemic Period*

5. *Planning for knowledge/skills transfer to support redeployed personnel*

In managing human resources and staff deployment to respond to the challenges stemming from an Influenza or COVID-19 Pandemic,

6. *The home will reference and act in accordance with such legislations as might be applicable in Canada and Ontario.*

7.
   - 7.1 The home may choose to request the Director of Human Resources (if applicable) or 3rd part contracted HR expert to research and advice the Administrator and Senior Management of the home as to legal and legislative considerations associated with but not limited to provisions of the (Ontario) Emergency Management Statues, Occupational Health and Safety Act, the Employment Standards Act etc, as per their relevance to measures established to help the home cope with anticipated human resources challenges in the context of a pandemic flu or COVID-19 outbreak.

   - 7.2 Refusal to work issues will be managed in accordance with provisions of applicable legislations and statues, the home Human Resource Policy, and with due considerations given to the well-being of staff.

To maintain ongoing readiness to respond to a pandemic flu or COVID-19 outbreak,

7. *The human resource and staff deployment plan as described in these policies and procedures will be regularly reviewed to maintain currency in applicability.*

PROCEDURES:

1. *Adjusting levels of programs/services in operation*

   - 1.1 Optimizing availability of incumbent human resources

     - 1.1.1 The home will maintain delivery of a full range of service programs for as long as possible during a pandemic flu or COVID-19 outbreak so long as human and material resources required to do so is available.

     - 1.1.2 Where a specific service is determined to be essential for the survival and medical well-being of incumbent residents who have no alternative recourse, the home will strive to continue operating that service within the limits of resources available during a pandemic flu outbreak.

     - 1.1.3 Services not deemed essential for the survival and medical stability of residents will be assigned a lower priority level, and be discontinued

     - 1.1.4 When human or material resources required is unavailable at enough, the plan outlined in the Business Continuation Policy for curtailing or suspending lower priority level services/programs will be implemented by the IPRCT or OMT.

1.1.5 All human resources (i.e. staff, placement students, and volunteers) made available by the curtailment of specific services/programs will be redeployed by the IPRCT or OMT to help sustain operation of essential services/programs.

1.2 Accessing additional/atypical human resources

During the Inter-pandemic Period,

1.2.1 The Human Resources Department (HR) (if applicable) or the Administrator in conjunction with the Director of Care, will explore with nursing service agencies about the practicability and cost of accessing additional human resources through them in the event of a pandemic flu or COVID-19 outbreak. Prospective contractual agreements will be established where feasible. Contracted services will need to follow established and mandated guidelines as indicated by the Ministry of Health Long Term Care and local Public Health Units specific to the outbreak definition upwards and including mandatory vaccination policies.

1.2.2 HR, and Coordinator of Volunteer and Advocacy (if applicable), will establish and maintain a database of all volunteers including information about qualification, experience, and special skills possessed (where applicable) to facilitate identification of available resource when targeted deployment is required during the Pandemic Period.

1.2.3 The Coordinator of Volunteer and Advocacy (if applicable) will conduct anticipatory discussion with local service clubs, church groups, schools, and other such potential sources of additional volunteers about their prospective availability.

1.2.4 HR (if applicable), and relevant Department Heads, will ascertain through discussion with training organizations at all levels, to establish and maintain database of students as supplementary human resources available that might be activated during the Pandemic Period.

During the Pandemic Period

1.2.5 When staff becomes aware of residents' family members expressing interest in assisting with delivery of some aspects of resident care at the home, the Administrator in conjunction with the appropriate departmental manager. If family members are considered for utilization in delivery of services, clear outlines of tasks will be provided with any relevant training provided before allowing family members to assist with delivery of some aspects of resident care. Family members will need to comply with all testing and surveillance guidelines and IPAC protocols consistent with the defined outbreak.

1.2.6 Where volunteers, including family members of residents are involved in sanctioned functions, staff will maintain vigilance to ensure that volunteers are not performing unauthorized control acts or tasks they have not been trained to do.

1.3 Risk management and legal liability

1.3.1 In the Inter-pandemic Period, the Chief Finance Officer (CFO) will research and report through the Chief Executive Officer (CEO) to the home Board of Directors and/or Administrator about insurance availability, affordability, and feasibility for utilizing volunteers, and family members of residents to deliver some aspects of care in the context of a pandemic flu or COVID-19 outbreak, and take such action as deemed necessary by the Board and/or Administrator.

1.3.2 The CFO will review this issue periodically as practice in the long-term care sector and insurance industry evolves and more information to guide future decision in this matter becomes available and present such revised recommendation through the CEO to the Board of Directors and/or the Administrator as might be necessary.

2 *Redeploying staff and other personnel*

2.1 The Coordinator – Human Resource Mobilization of the IPRCT or OMT, in consultation with other IPRCT or OMT members, will take lead responsibility for coordinating redeployment and assignment of staff, students and volunteers during the Pandemic Period.

2.2 Review and adjustment of Master Schedule and staff vacations
Once the home Influenza Pandemic Response Plan is activated,

2.2.1 All employees are to continue reporting to their normal duties unless specifically directed to do otherwise.

2.2.2 All previously approved vacations will be suspended until the staffing situation is stabilized, and the IPRCT or OMT directs the effect departmental managers to advice staff otherwise.

2.2.3 The home will compensate staff for expenses of cancelled vacation packages, that cannot be deferred, and if refund from the package retailer is not possible.

2.2.4 All staff on leave will check in with their immediate supervisor. The latter will consult with the IPRCT or OMT and advice staff as to re-deployment as required.

2.2.5 Departmental managers in conjunction with the IPAC Lead will review the Master (and associated) Schedules to identify areas vulnerable to shortages. They are to consult with the Coordinator of Human Resource Mobilization to arrange for staff re-deployment as necessary.

2.3 Minimum staffing levels for each program/service will have been established during the Inter-pandemic Period to accommodate reduced staff availability, and an augmented level of staffing defined with which to sustain essential program/service operations. (Refer to Procedure 4 below in this policy document for details.)

2.3.1 Where lower priority programs/services are curtailed, staff resources made available will be redeployed to sustain essential services/programs. It is expected that staff will have to be redeployed across services/programs, departments, divisions, and centres.

2.3.2 Consideration will be given to compatibility of skills required in adapted work roles and competence of personnel to be redeployed. Where instruction or training to perform specific tasks is required, such will be provided.

2.4 Health care workers' ethical duty to provide care will be referenced.

2.4.1 By virtue of the home being a health care provider organization, all employees engaged in delivering direct resident care or in support of organizational functioning, are considered health care workers, and are expected to honor the applicable ethical duty to continue providing care

2.4.2 Employees who are members of regulated health and social services professional colleges are expected to abide by their respective ethical codes of conducts to continue meeting the needs of clients in their care

2.4.3 Once a pandemic flu or COVID-19 outbreak is declared, the home will constantly monitor the health and operational status of its workforce through provisions of the *Surveillance, Reporting, and Communication* Policy, *Containment and Risk Reduction Policy*, and other relevant the home infection control policies.

All staff, students, and volunteers will fall into one or more of the following categories at some point during the Pandemic Period:

- Those who have been struck down with the virus
- Those who are at home acting as primary caregivers;
- Those who have managed to avoid the virus;
- Those who are in recovery mode and physically able to return to work;
- Those who have been effectively protected through vaccination (when available)

In the event of severely restrictive availability of human resources to deliver essential care and services, decision will be made by the IPAC Lead in conjunction with the Administrator with reference to directives issued by the local (public) health services (PHU) as to which categories of staff, students, volunteers, essential caregivers might work in resident care and non-resident-care areas.

2.5 Guidelines for the home staff working for multiple employers.

2.5.1 When the risk of the pandemic flu or COVID-19 spreading is still considered low by the PHU, the home staff who are also concurrent employees of other organizations will be encouraged to choose and stay with only one employer through the Pandemic Period.

2.5.2 Where risk of infection is deemed high by the PHU, the home might require that individuals only continue working at the home facilities until the Pandemic Period is declared over and/or directives may be enforced through governmental agencies banning dual employment. The home will abide by the directives and/or consider initiating a “one employer” policy during the active outbreak.

2.5.3 External expert advice by PHU, and the Ministry of Health and Long-Term Care – Emergency Management Branch, will be sought by the IPAC Lead, as necessary, to inform such decisions.

3. *Protecting and supporting employees*

3.1 Protection for staff

In long-term care homes or community health services settings, where people with infectious diseases are treated, and maintaining “total protection” or “zero risk” for residents, visitors or health care workers is impossible. However, the home will take all possible steps to protect staff – and reduce the risk of infection while providing care, including:

3.1.1 Subscribing to the Ontario Health Plan for Influenza Pandemic (OHPIP) enumeration program for healthcare staff in essential positions and maintaining the database of the home staff for purposes of prioritizing issuance of prophylactic medication, and immunization. This database is maintained by IPAC Lead of each the home and kept updated.

3.1.2 Seeking instruction from the PHU(s) as to provisions for community services and other staff, who are not initially included in the OHPIP enumeration plan, but who will be deployed during the Pandemic Period to assist with resident care in essential services/programs areas

3.1.3 Providing staff with appropriate personal protective equipment (PPE) (i.e., face shields, masks, gloves, gowns) as prescribed under the OHPIP.

3.2 Appropriate Protection

3.2.1 The Manager – Occupational Health and Safety (if applicable), the IPAC Lead, the Administrator, and the Joint Occupational Health and Safety Committee will jointly oversee implementation of appropriate health and safety, infection prevention and control programs; and augmenting them with directives issued by the PHU(s) during a pandemic outbreak.

3.2.2 The IPAC Lead will arrange for relevant training to be provided to staff as needed to promote better practice in surveillance, infection prevention and control while caring for influenza or COVID-19 residents.

3.3 Acknowledging the commitment of employees working in high-risk situations

The home will commit to accessing all available resources through government and such other corporate/community resources as might be available to acknowledge gratitude for the commitment and sacrifices made by staff in continuing to care for residents in the context of risk during an Influenza Pandemic.

3.4 Attending to staff well-being during the Pandemic Period

Managers and supervisors at each level of responsibility will:

3.4.1 Give due consideration to the burden of stress on their direct reports engendered by working at a setting and time of risk and having to juggle between familial and work responsibilities;

3.4.2 Address staff need for rest and shift rotations when managing staff scheduling, and calling off-duty staff in to cover shortages;

3.4.3 Facilitate mobilization of peer support where appropriate, and facilitate access to more specific psychosocial support resources when necessary; and,

3.4.4 Support employees in addressing familial care needs and obligations, including but not limited to child and elder care provisions, and compassionate leaves for funerals etc.

3.4.5 Pre-plan with the Human Resources Manager(if applicable) and/or departmental manager, during the Inter-pandemic Period, for:

- Provisions for staff choosing not to return home between work-shifts to access rest facilities – e.g. on-site designated staff quarters, and/or, contingency agreements with local hotels/motels to block rent rooms for use;

- Meals for staff working extended shifts;

- Transportation support;

- Childcare and/or eldercare, and other family support assistance…etc.

The IPRCT or OMT will

3.4.6 Monitor and address issues of staff and client/resident morale during the Pandemic Period and arrange for such intervention as available resources might allow during this period.

3.4.7 Delegate to the Director of Care, responsibility for helping staff who require them to access counselling support, referral to community resources, and other Employee Assistance Program (EAP) provisions

4 *Pre-establishing minimum staffing thresholds for all functional areas*

Where essential services/programs might have to be operated with reduced staff and modified functional objectives, it is essential that those who best understand the operation

of each service/program be involved in pre-establishing what constitutes the absolute minimum level of essential services, and recommending human resources required to carry them out.

4.1 The Administrator, Director of Resident Care, and the Director of Social Service (if applicable), will convene working group(s) comprised of management and frontline staff during the Period to review service/program and operational support areas that normally report to them, and

4.1.1 Identify the "*minimum* client/resident care needs" profile of each area if level of service delivered is to be compromised by staffing shortage;

4.1.2 Identify and maintain a list of care tasks that can be delegated to personnel not normally involved in providing direct care in a long-term care home setting, with informational/instructional support;

(Note: "Controlled Acts" as described in the Registered Health Professions Act are not to be included unless they can be delegated to other Regulated Health Professionals authorized to carry out such "Controlled Acts")

4.1.3 Identify the absolute minimum number and composition of regulated – i.e. number of RN, RPN…etc. – and non-regulated personnel required to continue providing essential care over a period of time that might last for 12 or more weeks.

4.2 Based upon the above information, an "**Absolute Minimum Staffing Plan**" to sustain operation of each service/program will be compiled.

4.2.1 Each Manager/Supervisor is to maintain the Absolute Minimum Staffing Plan(s) for his/her area(s) of responsibility and provide a copy to his/her Department Head and/or Administrator. The latter will provide these to the IPRCT or OMT during the Pandemic Period to facilitate coordination of implementation.

4.2.2 Senior Managers in non-client care areas will oversee similar processes during the Inter-pandemic Period to develop Absolute Minimum Staffing Plans for the areas that normally report to them.

4.2.3 Senior Managers with no direct reports (i.e. the Director of Corporate Development, and the Director of Quality Improvement) will assist with such processes as per instruction of the CEO.

4.2.4 The IPRCT or OMT Coordinator of Human Resource Mobilization will refer to these Absolute Minimum Staffing Plans when coordinating redeployment of staff and other human resources during the Pandemic Period.

4.3 The IPRCT or OMT Coordinator of Medical Services will liaise with physicians affiliated with the home to coordinate delivery of medical coverage for essential services/programs during the Pandemic Period.

5 *Planning for knowledge/skill transfer to supporting personnel being redeployed*

5.1 To optimize utilization of available human resource in a time of scarcity, staff will be redeployed, and student workers as well as volunteers will be assigned, to perform diverse tasks. To ensure competent performance and confidence by all concerned:

A "Skills Inventory" will be maintained in which

- Each Department is to define core activities in their respective functional area essential to business continuation during the Pandemic Period;
- All client care and business function departments are to document critical work processes that need to be maintained during the Pandemic Period. Department managers are to ensure that such documentations are prepared, and the location of their retention known to ensure accessibility;
- HR (if applicable) and/or Department managers, will address how cross-training and skills-development might be implemented in the most practicable way to ensure availability of human resource to discharge RHPA regulated acts.

5.2 When redeploying staff, students, essential caregivers, and volunteers, care will be taken to:

- Match skills, capability, and personal suitability with required tasks, and
- Provide tasked individuals with the necessary information, instruction and training required to perform those functions.
- Ensure such orientation and instructional information to be provided through incumbent staff modeling behavior, or access to job action sheets before they are put in a position of delivering specific services.

6. *Consistency with Legislative and Statutory Provisions*

6.1 The IPAC Lead, during the inter-pandemic period, will advise the IPRCT or OMT respectively to ensure compliance of the home Influenza & COVID-19 Pandemic Response Plan with corresponding public policy provisions – including but not limited to "Emergency Management Statues" concerning human resource practices.

7. *Maintaining currency of the Human Resource and Staff Deployment Policy*

7.1 This policy, for managing human resources and staff deployment at the home under circumstances of constraint precipitated by a pandemic outbreak, will be reviewed by the IPAC committee at least annually, and amended, as necessary.

7.2 Department managers will ensure that the "Absolute Minimum Staffing Plan" for each essential service/program is to be reviewed annually and amended as necessary unless significant change in program design and profile of clients/residents has occurred requiring more immediate amendment.

Note: Portions of this policy has been reproduced or paraphrased from the document *A Guide to Influenza Pandemic Preparedness and Response in Long-Term Care Homes* (2005) produced by the MOHLTC-Emergency Management Unit

Pandemic Preparedness Checklist

Section 1

	Does the LTCH [long-term care home] have an influenza/respiratory infection/COVID-19 outbreak plan?
	Is the influenza/COVID-19 plan reviewed/updated regularly?
	Does the LTCH have an influenza/COVID-19 pandemic plan or a section in its influenza/respiratory infection/ COVID-19 outbreak plan that deals with the potential impact of an influenza or COVID-19 pandemic?
	Does the LTCH have an emergency or disaster plan?
	Has the LTCH developed plans to ensure continuity of services in the event of internal emergencies (lack of water, hydro, food, or natural gas failure) related to a disruption of community services?
	Are emergency/continuity plans reviewed/updated regularly?
	Does the LTCH have an evacuation plan?
	Is the evacuation plan reviewed/updated regularly?
	Does the LTCH have a collaborative planning relationship with other care organizations in the community (local public health unit, emergency medical services, LHIN, acute care hospitals)?
	Have the planning partners developed criteria to determine where and how people will be cared for in the event of a pandemic?

Section 2

	Does the LTCH have an interdisciplinary pandemic planning committee and/or a pandemic outbreak management team that include representatives from administration?
	Does the LTCH have a designated Infection Control Professional (ICP) and back-up and a designated Occupational Health and Safety representative and a back-up who are known to the staff and are available 24/7?
	Are staff aware of their roles and responsibilities during a pandemic outbreak?
	Is there a designated area in the facility that staff can obtain information on/be altered to a potential influenza pandemic?
	Is there a chain of command for implementing the pandemic plan? (If Administrator is not available, who is next in command?)
	Is there a designated assembly point where all personnel report? Does it change if staff are involved in resident care or have administration responsibilities?
	Does the LTCH have a designated command centre?
	Have provisions been made (space, equipment, communications) for extra people who may come to the command centre to provide services (volunteers and outside agencies)

Section 3

	Does the LTCH have an up-to-date assessment of residents' essential care needs?
	Has the LTCH identified residents who could be cared for in other settings if necessary?
	Has the LTCH identified residents at high risk of complications from influenza and identified strategies to reduce the risk?
	Is information from ongoing resident assessments incorporated into the resident assessment plan?
	Does the resident assessment plan specify the skills/expertise required to meet the resident's needs?

Section 4

	Has the LTCH identified essential services that must be maintained during a pandemic?
	Has the LTCH identified non-essential services that could be reduced or curtailed?
	Does the LTCH have a mechanism to contact outside services (physiotherapy, occupational therapy, dental services) in the event of a pandemic outbreak

Section 5

	Has the LTCH identified priority groups for antiviral treatment and prophylaxis?
	Has the LTCH identified priority groups for vaccine?
	Is the enumerations tool for priority access to antivirals and vaccine reviewed/updated yearly?
	Does the LTCH have adequate capacity to store antivirals?
	Does the LTCH have an initial supply of antivirals?

Section 6

	Has the LTCH identified the supplies required during an influenza pandemic?
	Does the home have contracts with local suppliers to provide medical equipment?
	Will these suppliers be able to fulfill contracts during an influenza pandemic? If not, does the LTCH have a back-up source of supply?
	Does the LTCH have access to an adequate supply of commonly used pharmaceuticals (Ciprofloxacin, Doxycycline, bronchial dilators?
	Has the LTCH identified and established relationships with other health care facilities outside the region as a means of accessing possible sources of needed pharmaceuticals, equipment, supplies and staff)?
	Has the LTCH made arrangements to obtain and transport supplies for life-sustaining supplies (for hemo-dialysis and peritoneal dialysis)?

Section 7

	Has the LTCH identified the skills that will be required during a pandemic?
	Has the LTCH identified the skills that existing staff – including administrative and non-patient care staff have– and provide
	Does the LTCH have a staffing contingency planning case 20% to 35% of staff are ill?
	Does the LTCH have a policy for addressing work refusal?
	Has the LTCH identified potential outside sources of human resources (nursing agencies, other community organizations, volunteers, family members)?
	Has the LTCH developed plans, to support staff during a pandemic (child care, transportation, psychosocial support, meals, accommodation, assistance with pet care)?
	Has the LTCH developed a plan for cohorting staff?

Section 8

	Has the LTCH established a communication system with the local public health unit and other partners?
	Does the LTCH have a plan for communicating with staff, residents, volunteers and family members during a pandemic, including the person/s responsible for notifying staff & families?
	Dos the LTCH have alternative methods of internal and external communication if main method of communication is not available?
	IS there an organized runner, messenger system as back-up for communication system and power failure?
	Has the LTCH established a designated are for media?
	Have key personnel been designated to control and take care of the needs of the media?
	Has the LTCH designated a media spokesperson? Is there a plan for this person to coordinate messages with local public health unit?
	Has the LTCH developed procedures for handling requests for information from the media? Are these provisions consistent with the *Public Health Information and Privacy Act* (PHIPA)?

Section 9

	Does the LTCH have the ability to lock down so entry and exit to all parts of the home can be controlled? Has this process been tested
	Have arrangements been made to meet and escort responding emergency service personnel?

	Have steps been taken to minimize and control points of access in the building and areas without utilization of lock-down procedures.
	Does the LTCH have the ability to communicate with individuals immediately outside the home in the event access is restricted?
	Does the LTCH security plan recognize the extent of the security problems for the individual home? These considerations include the uniqueness of the physical plant, geographic location, entrances.
	If outside staff is required to meet the residents' needs during a pandemic, are their credentials verified?

Section 10

	Have provisions been made for the internal traffic that allow for movement of residents through corridors and staff movement throughout their areas? (designated unit/home area staff room instead of communal room).
	Does the LTCH have plans to restrict access in affected areas of the home?
	Will elevators be staffed and controlled?
	Is there a designated entrance and exit for both vehicles and people?
	Has the LTCH made provisions for deliveries (supplies and equipment)?
	Is there authorized vehicle parking?
	Has the LTCH made arrangement s for signs to direct authorized personnel and visitors to proper entrances?

Section 11

	Does the LTCH promote annual immunization of staff and residents?
	Does the LTCH routinely assess residents for febrile respiratory infection (FRI) and/or influenza-like illness (ILI) when applicable?
	Does the LTCH encourage staff to report FRI or ILI symptoms?
	Does the LTCH currently screen visitors for FRI or ILI?
	Does a process exist to notify infection control designate within 24 hours when an outbreak is suspected?
	If so, is this process clearly communicated and readily available to all key staff in the organization?

Section 12

	Does the pandemic plan specify who is responsible for the training program?
	Does the plan include methods for ramp-up and quick training for new and altered roles (have policies and procedures been made, have job actions sheets been developed)?
	Does the LTCH have ongoing mandatory pandemic training programs?
	Does the LTCH provide pandemic education material at staff orientation to raise staff awareness?
	Does the program provide ongoing pandemic education to keep staff informed and procedures/practices up-to-date?
	Does the hospital/health care facility routinely provide training on the proper donning and removal of personal protective equipment?

Section 13

	Does the plan include a mechanism to deal with anticipated increases in visitors seeking to gain entrance?
	Has the LTCH made provisions to handle medical and emotional situations resulting from the anxiety and shock of the pandemic situations?
	Have personnel been designated to control and take care of issues that arise due to visitors?
	Does the home have a plan to reduce the risk of visitors entering the home during pandemic (security, signage, restricted access)?

Section 14

	Does the LTCH have a system for the safekeeping of personal items removed from residents who have died?
	What is the mortuary capacity of the home? Is off-site surge morgue capacity available (assess community capacity with local funeral homes)?

Section 15

	Has the LTCH made plans to relocate residents and staff to an immediate area of safe refuge within the LTCH in the event the area must be evacuated (to facilitate the isolation of residents with ILI)?
	Has the LTCH planned with other long-term care homes and other services to relocate residents of the LTCH is unable to meet residents' needs (transfers between hospitals and long-term care homes, local LTCH partnering to support each other by delegating certain resident care activities to one organization while other focuses in the care of ILI/FI residents?
	Has the LTCH identified temporary locations where residents and staff could be housed in the event of an evacuation (a power failure)?
	Does the LTCH have a plan for the transportation required to move people to a temporary location?

A Guide to Influenza Pandemic Preparedness and
Response in Long Term Care Homes
Emergency Management Unit,
Ministry of Health and Long-Term Care
December 2005