LONG TERM CARE AND SENIORS SERVICES PANDEMIC PLAN

July 10, 2022

COUNTY OF SIMCOE

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PART 1 – PLANNING OVERVIEW

INTRODUCTION

Planning is a key component of emergency response. Regardless of whether an emergency is human-caused, health-related or environmental in nature, ultimately a successful response requires effective planning. As the COVID-19 pandemic outbreak evolves, and the threat of other pandemics is of real concern, governments, agencies and businesses around the world must continue to prepare for this type of health emergency.

A pandemic outbreak in Ontario has significant impacts to residents in Long-Term Care Homes (LTCSS). Viruses are introduced into LTCSS by staff, visitors, and residents leaving and entering the facility, which can spread easily in these closed communities. Because of their age and underlying medical conditions, most people living in LTCSS who contract a virus are at an increased risk of complications. During seasonal influenza outbreaks in LTCSS, up to 70% of residents and staff may become infected. Based on an attack rate of 35% at the peak period of a pandemic wave, between 20 to 25% of LTCSS staff may fall ill and be unable to work for a period of time. Long-term Care homes across Ontario have emergency plans and infection prevention and control programs in place to prevent and manage respiratory infection outbreaks, including seasonal influenza.

In 2006, the Simcoe Muskoka Health Sector Emergency Planning Committee, led by the Simcoe Muskoka Health Unit, the County of Simcoe and the District Municipality of Muskoka, developed the Simcoe Muskoka Pandemic Influenza Plan. Using this Plan as a guide, along with learnings from the COVID-19 pandemic, the Corporation of the County of Simcoe has developed a Pandemic Plan for the four long-term care homes it is the operator: Georgian Manor in Penetanguishene, Trillium Manor in Orillia, Simcoe Manor in Beeton, and Sunset Manor in Collingwood.

The goals of this Simcoe County Pandemic Influenza Plan for Long-Term Homes are:

- To help long-term care homes prepare for a pandemic.
- To reduce the spread of a pandemic outbreak within LTCSS among residents, staff, family members and volunteers.
- To maintain essential care and services for residents during a pandemic in order to keep them in the Long-term Care Home
- To make effective use of staff skills and knowledge during a pandemic.
- To identify services in LTCSS that can be reduced, modified or curtailed during a pandemic.
- To ensure that workplace health and safety standards are maintained to support staff, families and volunteers in meeting resident care and service needs.
- To minimize serious illness and overall deaths.

In order to maintain consistency with the Simcoe Muskoka and provincial plans, the details of this plan mirror those foundational documents cited above. Pandemic planning consistently evolves. As circumstances change, internal and external, local and international factors will influence its content and future direction. This Plan allows for a timely, coordinated, efficient response to a pandemic outbreak in Simcoe County. Further, this Plan may be used as a response to a variety of health-related emergencies or pandemic events

The County of Simcoe Pandemic Plan for Long Term Care and Seniors Services is divided into three parts:

PART I – Planning Overview

The planning overview includes a background and explanation of the World Health Organization's (WHO) Pandemic Phases, as well as the assumptions, ethical framework and legal/legislative authority underpinning this plan.

PART II – Planning Structure & Processes

Planning structure & processes identifies public health, provincial, municipal and LTCSS site relationships, roles, responsibilities and response protocols.

PART III – County of Simcoe LTCSS Pandemic Response Measures

The third section identifies specific measures for LTCSS to implement in a pandemic and forms the basic framework of the plan, which is divided into seven areas:

1. **Surveillance**
   Surveillance is the collection and analysis of data. In the event of a pandemic, surveillance will be used to determine when, where and which viruses are circulating, and which segments of the population are at risk. Surveillance information will be used by decision- makers to monitor trends and to plan an appropriate health emergency response. This section outlines surveillance activities presently underway in Simcoe Muskoka and those that are being coordinated and developed.

2. **Vaccines and Prophylactics**
   Vaccination is an important tool in preventing viruses. However, in the event of a pandemic, the development of a vaccine may take several months from the time the virus has been identified. Until then, anti-virals may be recommended for use as a preventative measure, when available, for identified groups such as healthcare workers and other essential service workers, and those who are ill. This section describes the activities of the health and emergency sector in the storage, handling and distribution of anti-virals, as well as activities related to vaccine distribution and immunization clinics.

3. **Public Health Measures**
   In a pandemic situation, it may be necessary to use non-medical interventions (or public health measures) to reduce the spread and impact of the virus. Public health measures can include but are not limited to providing public education; issuing travel restrictions and screening travelers; conducting case and contact management; closing schools; and restricting public gatherings. This section outlines the activities of each sector in the preparation for and response to the implementation of public health measures. These include screening, self-monitoring, quarantine & isolation.

4. **LTCSS Pandemic Control Measures**
   These include specific measures to be implemented for residents, staff/volunteers and visitors, including options for resident care. It also address changes or alterations in resident transfers, services as well as outline different levels of IPAC precautions.

5. **Health Services**
   The provision of health services during an influenza pandemic could be the most challenging aspect of a pandemic response. A pandemic will place significant additional demand for services on a health care

system that is already working to maximum capacity. A pandemic response will most likely need to reduce or stop some areas of health services and program delivery. It will also have an impact on health care professionals in terms of duties, hours of work and working conditions. This section identifies activities related to the continuation of health care services and redeployment of staff during a pandemic.

6. **Emergency Response**
   Although public health authorities will lead the response in a pandemic influenza situation, all health sector organizations and emergency responders will play a key role in an overall coordinated emergency response. A coordinated emergency response requires that emergency management structures and communications systems are in place, and that health agencies and emergency responders are prepared. This section outlines the activities required to ensure that regional emergency response plans and structures are in place. This section also identifies activities related to the continuation of health care services and redeployment of staff during a pandemic. Include PPE, co-horting, prioritization of calls.

7. **Communication**
   Efficient, accurate and coordinated communications will be a key component in a pandemic influenza response. Communication considerations include assessing public and provider communications needs; ensuring communications structures and protocols are in place; and educating the public about pandemic influenza. This section describes individual agency communications activities, as well as activities designed for a coordinated approach

WHAT IS A PANDEMIC

A pandemic is the global outbreak of a disease. Pandemics occur when new viruses or novel strains emerge which can infect people easily and spread from person to person. There are many examples in history, the most recent being the COVID-19 pandemic, declared by the World Health Organization on March 12, 2020.

Pandemics are generally classified as epidemics first, which is the rapid spread of a disease across a particular region or regions. COVID-19 began as an epidemic in China, before making its way around the world in a matter of months and becoming a pandemic. However, epidemics do not always become pandemics. The Zika virus outbreak that began in Brazil in 2014 and made its way across the Caribbean and Latin America was an epidemic, as was the Ebola outbreak in West Africa in 2014-2016.

Coronavirus (COVID-19) is a large family of viruses that cause illness ranging from the common cold to more severe diseases. What we are experiencing now is a new strain of the coronavirus that has not been previously identified in humans. Four known human coronaviruses cause a common cold, while others cause more severe disease. Middle East Respiratory Syndrome (MERS) is one such example. Since September 2012, there have been 2562 confirmed cases of MERS with 881 associated deaths. The case fatality rate of MERS is around 34%1. Severe Acute Respiratory Syndrome (SARS) is another coronavirus we experienced in Ontario. The 2003 outbreak had a case fatality rate of around 10%.

Influenza is the most common type of pandemic, being 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 and 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 diarrhea (in children). Many different illnesses, including the common cold, can have similar

While most healthy people recover from influenza without complications, some people – such as older people, and people with certain health conditions – are at high risk for serious complications. Some of the complications caused by influenza are pneumonia (bacterial or viral), dehydration, and worsening of

chronic medical conditions, such as congestive heart failure, asthma, or diabetes. Patients may develop sinus problems and ear infections.

Viruses such as influenza and COVID-19 are highly infectious and are *directly* transmitted from person to person, primarily when infected people 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).

The incubation periods can vary from a few days up to weeks, depending on the virus. Infected individuals may be able to transmit the virus for hours or days before symptoms appear.

Strains of influenza and other viruses circulate throughout the world all the time. When does a strain cause a pandemic? Pandemics arise when all four of the following occur:

a. a new virus or novel strain emerges
b. the virus can spread efficiently from human to human
c. the virus causes serious illness and death
d. the population has little or no immunity to the new virus

WORLD HEALTH ORGANIZATION PANDEMIC PHASES

In response to lessons learned from the Influenza A (H1N1) 2009 pandemic, the World Health Organization (WHO) revised the global phases. The phases, based on epidemiological, and clinical data, are used to describe the spread of a new virus or novel strain around the world, taking account the disease it causes.

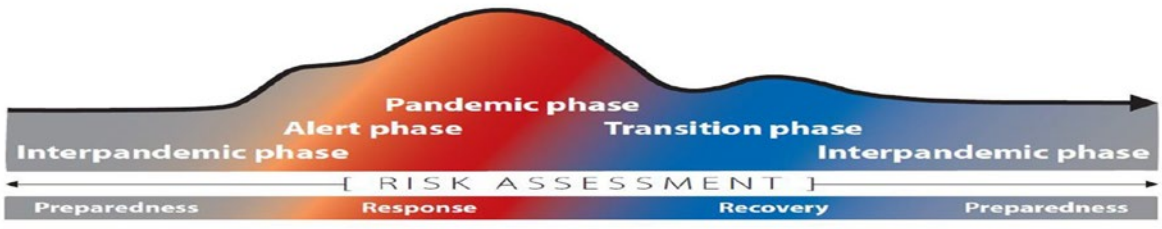
Inter-pandemic phase: This is the period between influenza pandemics. During this period Public Health and health care sector organizations monitor for developing threats, update emergency plans and may run exercises to prepare for disease outbreaks and pandemics.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the inter-pandemic phase may occur.

Pandemic phase: This is the period of global spread of human influenza caused by a new subtype based on global surveillance. Movement between the inter-pandemic, alert and pandemic phases may occur quickly or gradually as indicated by the global risk assessment, principally based on virological, epidemiological and clinical data.

Transition phase: As the assessed global risk reduces, de-escalation of global actions may occur, and reduction in response activities or movement towards recovery actions by countries may be appropriate, according to their own risk assessments.

Figure 2.1: The continuum of pandemic phases*



*This continuum is according to a "global average" of cases, over time, based on continued risk assessment and consistent with the broader emergency risk management continuum.

ONTARIO HEALTH PLAN FOR AN INFLUENZA PANDEMIC (OHPIP)

In March 2013, the Ontario Ministry of Health and Long-Term Care (no Ministry of Health) released the Ontario Health Plan for an Influenza Pandemic (OHPIP). This is the fifth edition of the plan and is aimed at health sector employers, health care providers and other health workers, emergency planners, health administrators and other provincial health system partners. The 2013 version of the OHPIP was updated to incorporate the priority lessons learned and best practices from the H1N1 pandemic in 2009. Previous versions of the OHPIP have used World Health Organization (WHO) and Public Health Agency of Canada (PHAC) response plans as a conceptual foundation.

The 2013 OHPIP is a response document to support the provincial health system in preparing for and responding to an influenza pandemic. It outlines anticipated response activities based on the severity of the pandemic virus. The actual response activities will be confirmed by the MOH at the time of a pandemic based on the epidemiology of the virus, impacts on the provincial health system and behavioural responses of the public.

The goals of the OHPIP are two-fold:
To minimize serious illness and overall deaths through appropriate management of Ontario's health care system.
To minimize societal disruption in Ontario as a result of influenza pandemic (OHPIP, 2013, p. 10).

Supporting document: Ontario Health Plan for an Influenza Pandemic (OHPIP)
http://www.health.gov.on.ca/en/pro/programs/emb/pan_flu/pan_flu_plan.aspx

ETHICAL FRAMEWORK

During a pandemic, governments, healthcare agencies, and community partners will have to make some difficult decisions. Considerations include allocation of scarce resources, prioritization guidelines for vaccines and medical countermeasures, curtailment of individual freedoms, and closing or re-opening public spaces, schools and businesses. Having an ethical framework in place can assist decision makers in making informed and well-founded decisions.

There should be stakeholder involvement in the decision-making process, with clear, accurate communication. The following table, reproduced with permission of Simcoe Muskoka District Health Unit, was adopted from their Infectious Diseases Emergency Response Plan. It has been adapted for this Plan to outline an Ethical Framework for Decision Making

ETHICAL FRAMEWORK FOR DECISION MAKING

Open and transparent	The process is open for scrutiny, and information about the basis for decisions and when and by whom they were made is publicly accessible.
	Decisions should not be arbitrary but rather be rational, proportional to the threat, evidence-informed and practical. Decisions should be made by people who are credible and accountable.
	Stakeholders are consulted, views are taken into account, and any disproportionate impact on particular groups is considered.
	Decisions should be revisited and revised as new information emerges. Stakeholders should have opportunities to voice any concerns they have about the decisions (i.e. dispute and complaint mechanism).
	There should be mechanisms in place to ensure that ethical decision— making is sustained. All those involved must accountable for their decisions.
	May be restricted in order to protect the public from serious harm.
	Individuals have a right to privacy, including the privacy of their health information. Any collection, use or disclosure of personal information will be done in compliance with governing legislation, including the *Personal Health Information Protection Act.*
	All people have an equal claim to receive the health care they need, and health care institutions are obligated to ensure sufficient supply of health services and materials. During a pandemic emergency, tough decisions may have to be made about who will receive antiviral medication and vaccinations, and which health services will be temporarily suspended.
	Health care providers (HCPs) have an ethical duty to provide care and respond to suffering. During an emergency, demands for care may overwhelm health care workers and their institutions, creating challenges related to resources, practice, liability and workplace safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e. to their own health, family and friends). When HCPs cannot provide appropriate care because of constraints caused by the pandemic, they may be faced with moral dilemmas.
	Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good. During a pandemic emergency, the greatest burden will fall on public health practitioners, other health care workers, patients, and their families. Health care providers will be asked to take on expanded duties. They may be exposed to greater risk in the workplace, suffer physical and emotional stress, and be isolated from peers and family. Individuals who are isolated may experience significant social, economic, and emotional burdens.
	Trust is an essential part of the relationship between the government, health system partners and the public. During a pandemic emergency, some people may perceive measures to protect the public from harm (e.g. limiting access to certain health services) as a betrayal of trust.
	A pandemic emergency will require solidarity among community, health system partners, and government.
	In our society, both institutions and individuals will be entrusted with governance over scarce resources, such as vaccines, ventilators, hospital beds and even health workers. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well- being.
	A family's right to make decisions on behalf of a child, consistent with the capacity of the child will be respected.

LEGISLATIVE AUTHORITY

Actions taken in response to an emergency must be guided by the legal/legislative framework which gives authority to the municipality, public health unit and other entities for their actions.

The following statutes may play a role and provide legal authority to respond to a pandemic at the provincial and the local level.

AMBULANCE ACT

https://www.ontario.ca/laws/statute/90a19

The Ambulance Act serves to ensure the existence, throughout Ontario, of a balanced and integrated system of ambulance services and communication services used in dispatching ambulances. Standards for the management, operation and use of these services while ensuring compliance with those standards shall also be in place.

CORONERS ACT

https://www.ontario.ca/laws/statute/90c37

Where a person dies as a resident in specified facilities, including, a retirement home, home for the aged or a nursing home, a psychiatric facility or an institution under the *Mental Hospitals Act*, the *Coroners Act* requires the person in charge of the hospital, facility or institution to immediately give notice of the death to the Coroner. Further, if any person believes that a person has died under circumstances that may require investigation, that person must immediately notify a coroner or police officer of the facts and circumstances relating to the death. The Coroner must investigate the circumstances of the death and determine whether to hold an inquest.

EMERGENCY MANAGEMENT ACT

https://laws-lois.justice.gc.ca/eng/acts/e-4.56/FullText.html

The Government of Canada is responsible for establishing, testing and evaluating policies, programs and other measures respecting the preparation, maintenance, and implementation by a government institution of emergency management plans. It is also incumbent on our government to monitor potential, imminent and actual emergencies and to advise other ministers accordingly. When such emergency exists or is likely to exist, they will coordinate the response to an emergency and coordinate the activities relating to emergency management with those of each province while supporting the emergency management activities of the provinces.

EMERGENCY MANAGEMENT AND CIVIL PROTECTION ACT (EMCPA)

https://www.ontario.ca/laws/statute/90e09

The *Emergency Management and Civil Protection Act* establishes the requirements for emergency management programs and emergency plans in the Province of Ontario. The *EMCPA* specifies what must be included in emergency management programs and emergency plans. Municipal councils are required to adopt emergency plans by by-law.

HEALTH PROMOTION AND PROTECTION ACT (HPPA)

https://www.ontario.ca/laws/statute/90h07

In Ontario, the Health Protection and Promotion Act requires Boards of Health to provide or ensure provision of a minimum level of public health programs and services in specified areas such as the control of infectious and reportable diseases, health promotion, health protection and disease prevention. Mandatory Health Programs and Services Guidelines published by the Minister of Health, set out minimum standards that must be met by Boards of Health delivering these public health programs and services.

Regulations published under the authority of the *HPPA* assist to control the spread of communicable and reportable diseases. *Regulation 569*, Reports, establishes the parameters within which those who are required to report communicable and reportable diseases to the Medical Officer of Health must operate. The Report regulation specifies the information that must be reported for diseases listed in the regulation and under certain conditions, such additional information that the Medical Officer of Health may require. (http://www.e-laws.gov.on.ca/DBLaws/ Regs/English/900569_e.htm)

A medical officer of health is authorized under s. 22 of the *HPPA* to issue an order under prescribed conditions to control communicable diseases. The content of these orders could include to an order requiring an individual to isolate him or herself, to place him or herself under the care and treatment of a physician (if the disease is a virulent disease, as defined in the *HPPA*) or to submit to an examination by a physician. Under certain conditions, a medical officer of health may also seek a court order under s. 35 of the *HPPA* to isolate an individual in a hospital or other facility for a period of up to four months.

FIXING LONG-TERM CARE HOMES ACT

https://www.ontario.ca/laws/statute/21f39

Under this Act, a long-term care home (LTCH) is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety, and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

Every LTCH shall ensure that the rights of residents are fully respected and promoted. This includes but is not limited to being treated with courtesy and dignity, protected from abuse, properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, live in a safe and clean environment, and afforded privacy in treatment and care. Each resident has the right to participate in the decision-making, development and implementation of his or her care, including the right to consent to or refuse care.

OCCUPATIONAL HEALTH AND SAFETY ACT (OHSA)

https://www.ontario.ca/laws/statute/90o01

The *Occupational Health and Safety Act* (OHSA) is enforced by the Ministry of Labour. The OHSA imposes a general duty on employers to take all reasonable precautions to protect the health and safety of workers. The duties of workers are, generally, to work safely in accordance with the OHSA and its regulations.

PERSONAL HEALTH INFORMATION PROTECTION ACT (PHIPA)

https://www.ontario.ca/laws/statute/04p03

PHIPA regulates the collection, use and disclosure of personal health information by health information custodians (a defined term in the *PHIPA*) and includes physicians, hospitals, long-term care facilities, medical officers of health, and the Ministry of Health and Long- Term Care. The *PHIPA* also establishes rules for individuals and organizations receiving personal information from health information custodians.

Consent is generally required to collect, use and disclose personal health information however, the Act specifies certain circumstances when it is not required. For example, the *PHIPA* permits disclosure of personal health information to the Chief Medical Officer of Health or medical officer of health without the consent of the individual to whom the information relates where the disclosure is for a purpose of the *Health Protection and Promotion Act*. Disclosure of personal health information without consent is also permitted for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

PUBLIC HOSPITALS ACT

https://www.ontario.ca/laws/statute/90p40

Hospitals are required to obtain ministry approval before using additional sites for hospital services. Cabinet has authorization to appoint a hospital supervisor on the recommendation of the Minister of Health. The Minister is then authorized to make regulations, subject to Cabinet approval, to address the safety of any hospital site and to deal with patient admissions, care and discharge.

The administrator, medical staff, chief nursing executive, staff nurses and nurses who are managers are required to develop plans to deal with:

i. emergency situations that could place a greater than normal demand on the services provided by the hospital or disrupt the normal hospital routine, and
ii. the failure to provide services by persons who ordinarily provide services in the hospital.

QUARANTINE ACT

https://laws-lois.justice.gc.ca/eng/acts/q-1.1/FullText.html?wbdisable=false

The purpose of the federal *Quarantine Act* is to prevent the introduction and spread of communicable diseases in Canada. It is applicable to persons and conveyances arriving in or in the process of departing from Canada. It includes a number of measures to prevent the spread of dangerous, infectious and contagious diseases including the authority to screen, examine and detain arriving and departing individuals, conveyances and their goods and cargo, which may be a public health risk to Canadians and those beyond Canadian borders

PART II – PLANNING STRUCTURE AND PROCESSES

ROLES AND RESPONSIBILITIES IN INTER-JURISDICTIONAL PANDEMIC PLANNING

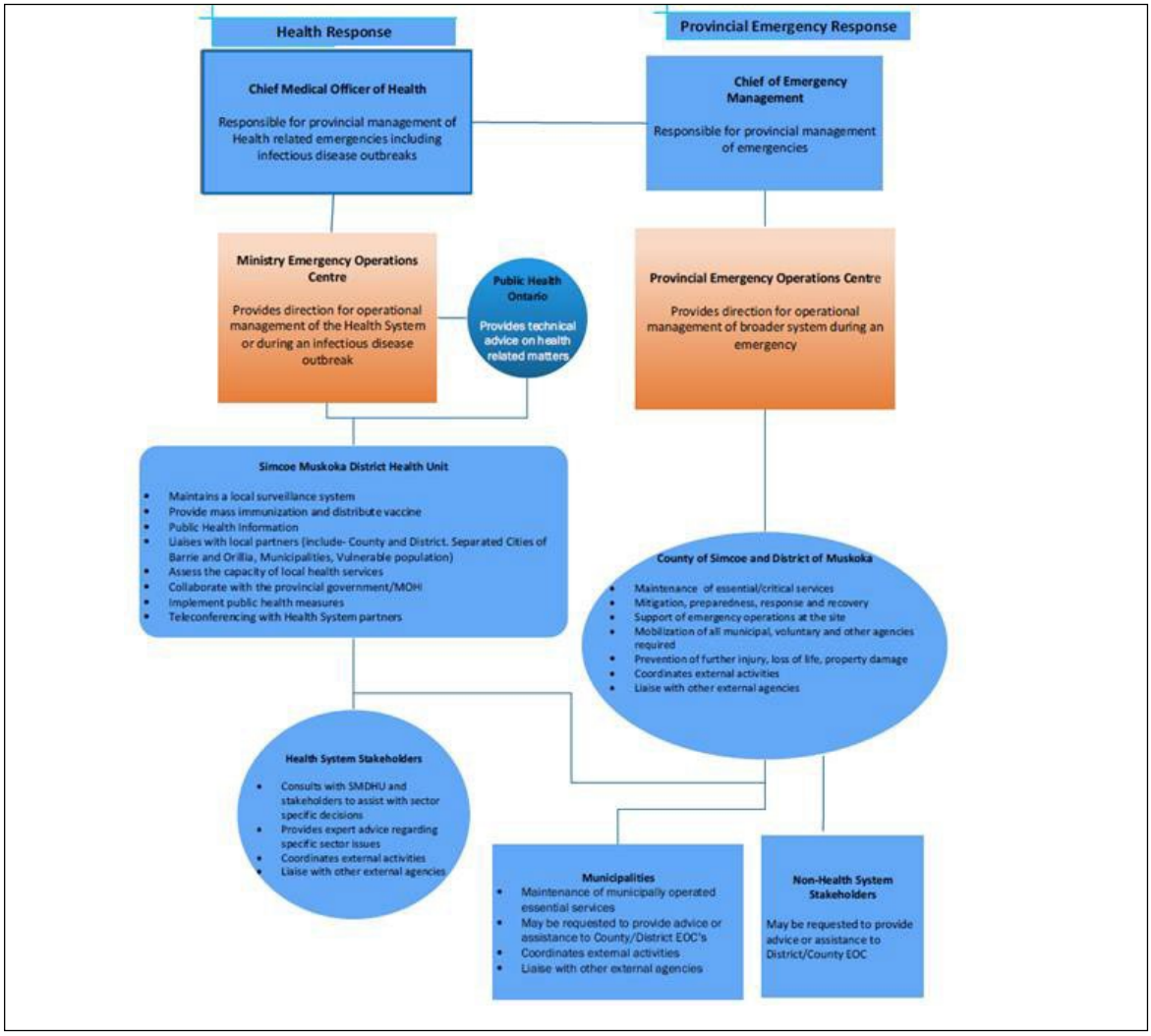
Response to a pandemic or Public Health Emergency of International Concern (PHEIC) requires coordination between multiple levels of government bodies, agencies and organizations. The World Health Organization has the authority to declare PHEICs and global pandemics. In Canada, effective response to a pandemic requires coordination through federal, provincial and municipal government and public health agencies.

Pandemic Planning and Response - International, Federal, Provincial/Territorial, Municipal and Public Health General Roles

ROLES AND RELATIONSHIPS FOR INFECTIOUS DISEASE EMERGENCY MANAGEMENT

Local public health authorities are responsible for planning local pandemic response with direction from both the provincial and federal governments. This requires liaising with local partners (e.g. hospitals, primary care providers, emergency responders, mortuary services) to carry out a coordinated response. Local public health authorities, through existing or enhanced surveillance, may be the first ones to detect cases within the region. It is essential that lines of communication within the community and with the province are clear and established in advance of a pandemic.

In preparation to infectious disease outbreaks and pandemics, the Simcoe Muskoka District Health Unit (SMDHU) has established an organizational response structure which identifies relationships between stakeholders (Figure*: Roles and Relationships in Infectious Diseases Emergency Management).* This response structure is designed to assist in the coordination of inter-agency response to a pandemic and identifies Emergency Operation Centres which may be activated in a pandemic



Ontario: Roles and Relationships in Infectious Diseases Emergency Management

ACTIVATION OF EMERGENCY PLANS AND EMERGENCY OPERATIONS CENTRES

WORLD HEALTH ORGANIZATION

The World Health Organization (WHO) is responsible for ongoing monitoring of infectious diseases around the world. They constantly monitor for new outbreaks of infectious disease including ones caused by novel viruses and pathogens.

Under the International Health Regulations (2005), the Director General of the World Health Organization may declare significant outbreaks as a Public Health Emergency of International Concern (PHEIC) or a Pandemic.

Definitions and Criteria

1. Epidemic: An outbreak of disease that spreads rapidly to a large number of people in a given population within a short period of time.
2. Public Health Emergency of International Concern (PHEIC): An extraordinary event which is determined to:
    i. constitute a public health risk to other States through the international spread of disease; and
    ii. potentially require a coordinated international response".
3. Pandemic: An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people

FEDERAL AND PROVINCIAL & LOCAL RESPONSE

A declaration of pandemic by the Health Organization triggers federal, provincial/territorial response within Canada. The Public Health Agency of Canada will identify that Canada is facing an impending pandemic or is already in a pandemic. Provincial and Territorial bodies within Canada will issue their own declarations of pandemic.

The Simcoe Muskoka Medical Officer of Health (MOH) or designate is notified the Ministry of Health when a pandemic is occurring in the Province of Ontario. Notification that a pandemic poses a threat in Simcoe County and the District of Muskoka will be made by the Medical Officer of Health. The SMDHU Pandemic Plan and supporting emergency plans are activated in whole or in part upon direction of the Medical Officer of Health when the following conditions apply:

- Pandemic alerts are issued by international, national, provincial or local sources
- Local case(s) or an outbreak of the pandemic virus is confirmed locally
- A pandemic is declared by the Premier of Ontario
- There is an expected impact of illness in the population which requires a coordinated a coordinated response by the health unit's staff and resources.

ACTIVATION OF LOCAL PLANS/EMERGENCY OPERATION CENTRES

The Provincial Office of the Fire Marshal and Emergency Management may notify municipal Community Emergency Management Coordinators (CEMC's) and recommend activation of emergency plans. When a disease outbreak or pandemic threatens the health of individuals locally, the MOH will alert municipalities in the County of Simcoe and District of Muskoka who may activate their Emergency Operation Centres (EOCs) to coordinate response to the outbreak.

The MOH may also request that health sector organizations and key community stakeholders activate their emergency response plans. Each agency will be impacted differently; therefore, individual agencies may implement their plans independently or in conjunction with the Health Unit and the County and/or the District.

The decision to activate Emergency Response Plans Emergency Operations Centres in Simcoe County and the District of Muskoka will be made by the County and/or the District emergency control group in consultation with the Medical Officer of Health. Municipal and regional emergency plans will be activated as local conditions escalate and the need for response measures increases. For more details on the activation of the County of Simcoe Emergency Community Control Group, please refer to the County of Simcoe Emergency Response Plan (ERP).

PANDEMIC PLAN ACTIVATION - COUNTY OF SIMCOE LONG-TERM CARE & SENIORS SERVICES

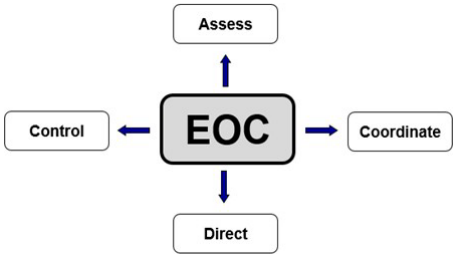
Vulnerable populations, such as residents in Long Term Care and Retirement Homes are often at greater risk in disease outbreaks. In the event that the County of Simcoe CEMC receives notification from the SMDHU MOH of a potential, impending, or occurring pandemic, the CEMC will advise the Chief Administrative Officer, and the General Manager, Health & Emergency Services. The General Manager will notify all site administrators and will make the decision regarding the activation of the County of Simcoe Long- Term Care & Seniors Services Pandemic Plan. When the LTCSS Pandemic Plan is activated the County's Emergency Response Plan is automatically activated in support of LTCSS. This enables the County of Simcoe Emergency Community Control Group to take actions to support the LTCSS department.

ROLE OF MUNICIPAL EMERGENCY MANAGEMENT

A key priority for Emergency Community Control Groups is to protect the health and safety of people when emergencies arise. The municipal Emergency Operation Centre (EOC) is a location where the emergency control group meets to coordinate response to emergencies. The County maintains two physical Emergency Operations Centres and has the option to meet in a virtual EOC on-line.

When the Pandemic Plan is activated, the County Emergency Community Control Group will meet to support the LTCSS department. Meetings will be set on an operational cycle and the goals of the County Control Group are to:

- Assess the situation
- Coordinate resources and services
- Establish priority action items and direct staff to carry out assigned tasks
- Control the emergency by mitigating effects/impacts



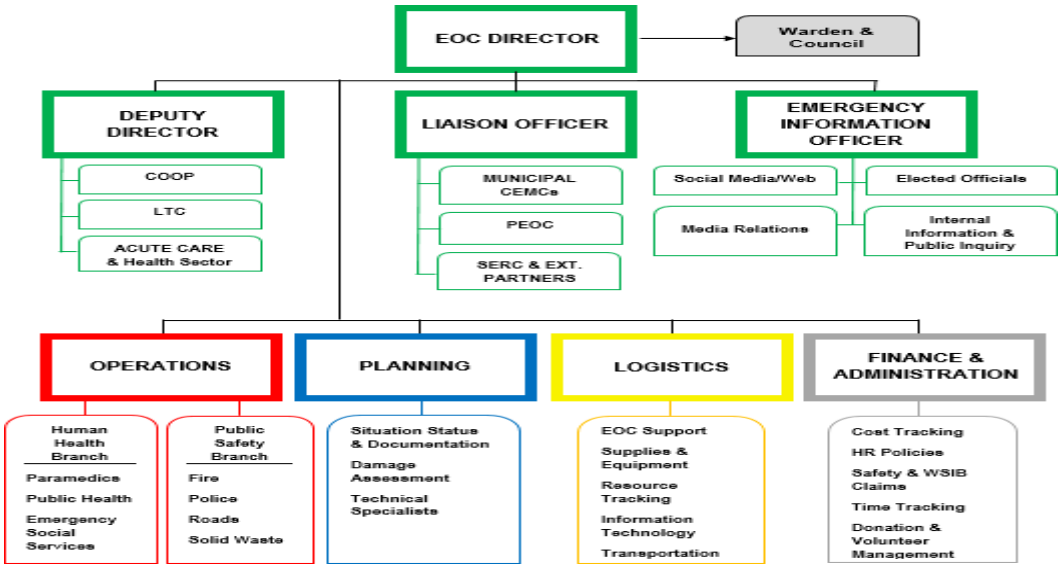
EMERGENCY MONITORING STATUS INDICATORS

The County has established Emergency Monitoring Status Indicators to identify specific phases of an emergency event and the actions or monitoring that the Community Control Group and County staff will undertake during each phase.

County Status ROUTINE GREEN	**Routine** conditions identifies that the Corporation is operating under normal conditions. Under these conditions the County maintains ongoing surveillance for abnormal events.
	Enhanced conditions indicates that an abnormal event, potential or actual emergency has been detected or is in development. Under these conditions the County enhances its surveillance and monitoring activities and takes appropriate related actions.
	Declaration of **Emergency** means that the County and/or two or more of its member municipalities is in an emergency response mode. Under these conditions the County implements its Emergency Response Plan and activates its Emergency Operations Centre (EOC) in order to coordinate the appropriate response activities.
	Recovery conditions means that the County is working to ensure a smooth transition from Enhanced or Emergency Conditions to Routine Conditions.

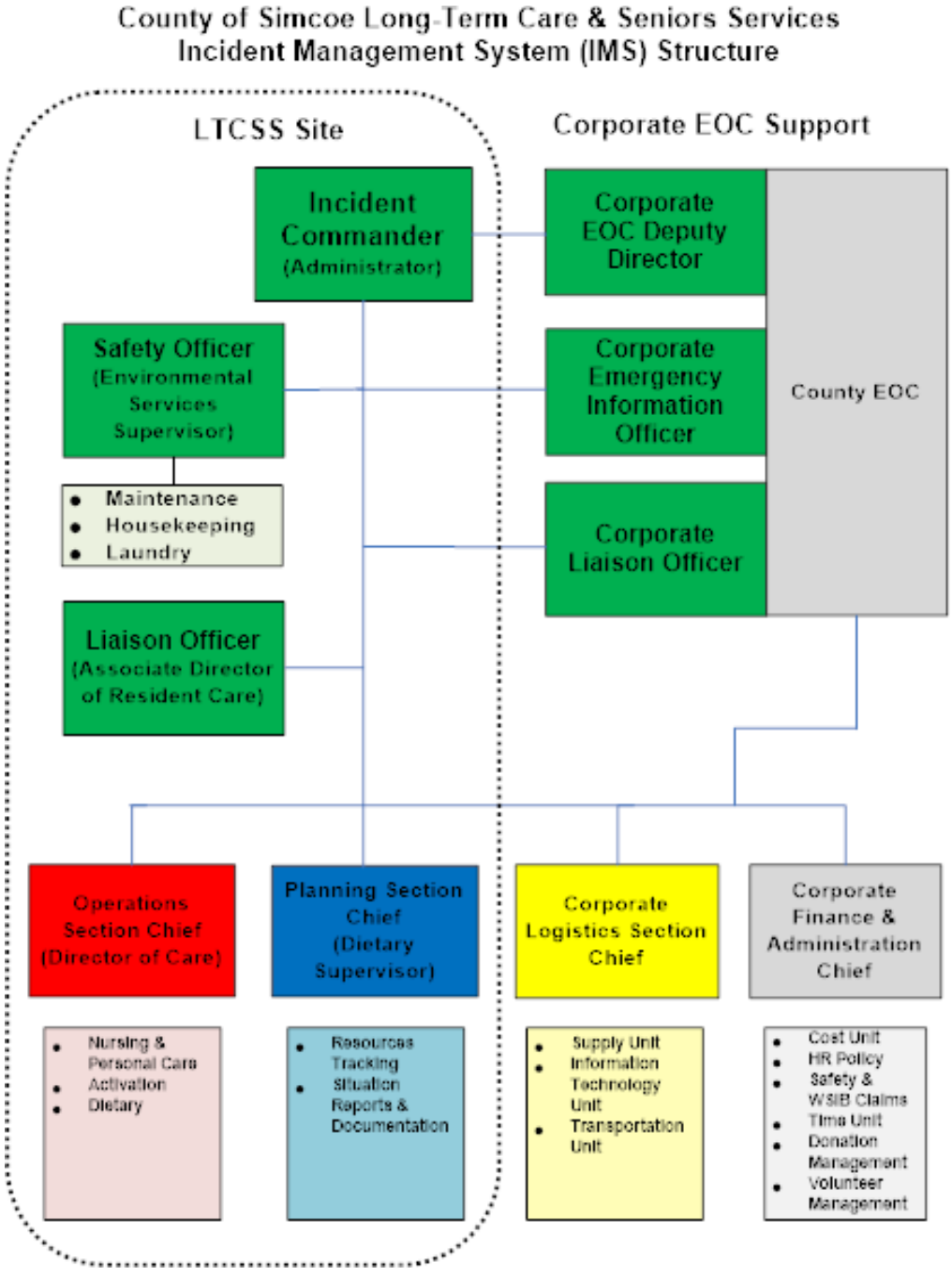
COUNTY OF SIMCOE EMERGENCY COMMUNITY CONTROL GROUP

The County of Simcoe uses an Incident Management System (IMS) organizational structure which defines clear roles, responsibilities and relationships between Community Control Group members. This structure facilities coordination with outside agencies and organizations who have implemented IMS. Details of the County's implementation of IMS are found in the County of Simcoe ERP.



INCIDENT SITE MANAGEMENT TEAM – INCIDENT MANAGEMENT SYSTEM (IMS)

To respond to emergency incidents, IMS is used by the County LTCSS department. The LTCSS IMS organizational structure below identifies the roles which are split between individuals who are on-site and County Community Control Group members who may support the emergency working remotely from the County EOC or attend on-site depending on the situation.



INCIDENT MANAGEMENT SYSTEM ROLES AND RESPONSIBILITIES*

Incident Manager	LTCSS Administrator
Safety Officer	Environmental Services Supervisor
Emergency Information Officer	Director Service Simcoe (Corporate)
Liaison Officer	Associate Director of Resident Care
Operations Chief	Director of Resident Care
Planning Chief	Dietary Supervisor & Corporate Control Group
Logistics Chief	Environmental Services Supervisor
Finance/Administration Chief	Finance Divisional Controller/HR Director (Corporate)

- **Incident Manager/Command**
  Assumes overall responsibilities for the incident, develops objective, sets priorities, delegates and oversees key management functions.
- **Safety**
  Monitors the safety conditions of all people at the incident and develops measures for ensuring their safety.
- **Liaison**
  Responsible for communicating with external government bodies, agencies, and organizations.
- **Emergency Information Officer (Corporate)**
  Responsible for facilitating communications with the media, public, internal and external stakeholders.
- **Operations**
  Responsible for ongoing provision of care for residents.
- **Planning**
  Develops the action plan to accomplish objectives, collects and evaluates information and intelligence, maintains resources status. Establishes plans for recovery / return to normal operations.
- **Logistics**
  Provides support, resources and other services to meet the needs of the incident and organization.
- **Finance/Administration (Corporate)**
  Monitors costs related to the incident, provides accounting, procurement, time recording and cost analyses. Administrative support for the IMS organization.
- **Human Resource Planning**
  Monitors working conditions, receives staff grievances, and deals with staff deployment and staff shortages.

Long Term Care & Seniors Services Emergency Response Team is comprised of:

- LTCSS staff on-site when the emergency plan is implemented
- LTCSS senior management staff
- County of Simcoe Community Control Group
- External emergency services and agencies

PART III - PANDEMIC MEASURES IN LTCSS

SURVEILLANCE

INTRODUCTION

Surveillance is the systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken. (World Health Organization, April 27, 2004)

Pandemic surveillance determines when, where and which viruses are circulating as well as those segments of the population that are at risk of illness, hospitalization and death. Ultimately, the surveillance information that is disseminated is utilized by decision makers to guide a public health response. For example, surveillance data can be used to:

- determine when a pandemic begins or enters a health jurisdiction, or
- assist in the identification of high-risk groups requiring anti-viral medications, vaccinations, or other prophylactic measures
- evaluate interventions.

Early detection of human cases provides the greatest opportunity for preventing or delaying further spread of a pandemic virus.

The local activities are dependent on MOHLTC directives and correspond with the local objectives identified in the OHPIP. Changes in WHO phase would affect the surveillance activities that the health unit would undertake.

OBJECTIVES

The over-arching surveillance objectives are:

1. Systematically monitor trends in health, disease and the determinants of health.
2. Rapidly detect unusual events, epidemics or other changes in the health or the determinants of health of a population.
3. Evaluate new or ongoing prevention and control measures.
4. Plan and set priorities for health policies and programs.
5. Suggest hypotheses concerning the determinants of health in populations.

Because LTC residents are highly vulnerable, the pandemic virus could spread quickly and easily from the community into the long-term care environment. Surveillance is a key component of detecting, preventing and managing the spread of pandemic pathogens. Someone with training in infection prevention and control should be responsible for the home's surveillance program. When pandemic activity has been reported in the community, LTCSS should enhance their surveillance.

During a pandemic, LTC facilities will:

- Continue to monitor residents for signs and symptoms associated with pathogen
- Conduct active surveillance of signs and symptoms in staff and new residents
- Complete any diagnostic testing as directed based on pathogen
- Notify the local medical officer of health of any disease activity of concern
- Continue to report daily line listings to the health unit as per current protocol

The appropriate surveillance and planning for a pandemic may reduce the number of people infected (i.e. the extent of the outbreak), the severity of illness, the number of deaths, and the amount of socio-economic disruption.

SURVEILLANCE AND SCREENING – RESIDENTS

1. Daily surveillance and documentation via line listing will be conducted on all resident Home Areas.
2. The Infection Control Lead or designate will review the line listing each day in collaboration with nursing staff to identify any trends or associated illness requiring follow up
3. Any clusters or trends will be considered a pending outbreak and consultation with Public Health will occur. Appropriate isolation precautions will be put into place and maintained for the affected residents while awaiting Public Health input and direction
4. Pathogen specific screening tools will be developed and implemented according to direction from Public Health and the Ministry of Long Term Care
5. Admission and transfers will occur as directed by Public Health and the Ministry of Long Term Care.

SURVEILLANCE AND SCREENING – STAFF AND VOLUNTEERS

1. Daily self-surveillance of staff and volunteers will be maintained at key entrances to each site
2. Surveillance communications will highlight the signs and symptoms of the illness, and areas of exposure risk that people may have visited. The communication shall also give direction to persons experiencing illness.
3. Persons exhibiting or reporting the surveillance signs and symptoms for the illness will be denied access to the facility or asked to leave the facility if signs or symptoms develop once on site.
4. All people exhibiting signs and symptoms of illness while working or volunteering will be assessed by a RN and directed to appropriate medical attention.

SURVEILLANCE AND SCREENING – VISITORS

1. Surveillance will be conducted in the same manner as staff or as directed by Public Health.
2. Active screening will be undertaken as directed by Public Health

MONITORING AND OUTBREAK MANAGEMENT

1. The Infection Control Lead for the Home is to be informed of all infections based on evidence based criteria:
    a. The RN or RPN will complete the Line Listing form when a resident presents with symptoms of an infection;
    b. The RN or RPN will complete the Line Listing form when a resident presents with symptoms of an infection.
    c. The signs and symptoms are noted under the type of infection.
    d. The RN or RPN indicates the type of treatment prescribed by the physician if applicable, and specimens/cultures collected and sent to the lab.
    e. Report to the Infection Control Lead.
    f. The Infection Control Lead will review the data and determine if the resident meets the criteria for the type of infection. The Infection Control Lead will follow up as needed and keep the surveillance data as part of the Quality Management program.

g. The Infection Control Lead will identify a cluster of infections and implement appropriate infection control interventions to address clusters and minimize the spread of infection.
h. The Home will follow public health guidelines in determining the presence of an infectious disease outbreak. Outbreak declarations are based on criteria associated with specific signs and symptoms, and established thresholds for infectious diseases, by category. Once an outbreak has been determined, the Home will communicate the case definition for subsequent surveillance measures.

2. The Infection Control Lead will activate outbreak management procedures, lead daily outbreak meetings, and will communicate with key internal and external stakeholders regarding care and service initiatives as required.
3. Outbreak management guidelines are included in LTCSS infection prevention and control policies.

REPORTING – INTERNAL AND EXTERNAL

The Infection Control Lead for the Home will be responsible for the reporting of all required information as requested by the Ministry of Long Term Care and Public Health to internal and external stakeholders as outlined in current legislation and Infection Control policies on Outbreak Management in collaboration with the Administrator or designate

The Administrator or delegate will maintain lines of communication with outside agencies (email address, conference calls) to ensure there is a process in place for the Home to receive pertinent external infection information.

Surveillance data will be submitted as required and requested to appropriate agencies

VACCINES AND PROPHYLACTICS

Vaccination is a primary means of preventing communicable disease and death from communicable disease (National Advisory Committee on Immunization, 2005). In a pandemic situation however, vaccines will not be available until many months after the pandemic strain has been identified.

Until a vaccine is available, there may be prophylactics and therapeutics recommended for use for specifically identified groups such as healthcare workers and other essential service workers. These will be distributed to facilities that have been identified by the MOLTC as those needing to provide a priority group with treatment or prophylaxis.

When a vaccine is available, it will be distributed as determined by Public Health to facilities and health care providers for vaccination.

In the early stages of a pandemic, and while the general public await access to a vaccine, specific strategies will be implemented to help minimize social disruption and care for those who are ill.

OBJECTIVES

The vaccine objectives are:

- To ensure that safe, effective vaccine programs are available as quickly as possible.
- To ensure that vaccines are allocated, distributed and administered to the appropriate groups of people.
- To monitor the safety and effectiveness of vaccination programs.

In the event of a pandemic outbreak, the Infection Control Lead will direct use of therapeutics and prophylactics upon receiving instructions from the Medical Officer of Health and/or the Medical Director.

For anti-viral use, further instruction can be found in the Infection Control Policy Manual

Determination of Pandemic Status as well as prophylactic use will be the responsibility of Public Health

STORAGE AND SECURITY

All vaccines will be stored / secured according to manufacturer's directions within a locked area, which may include refrigeration, with access limited to key players in the vaccination process as determined by the Infection Control Lead.

Storage location and protocols should address:

- Proper conditions to maintain the safety and efficacy of the product (e.g. cold chain requirements)
- Inventory management (including monitoring of expiry dates where relevant) and restocking
- Security of supplies, particularly where shortages or potential tampering is an issue, including access and requisition authority
- Contingency planning for cases where the event takes place during a routine immunization campaign and existing refrigerated storage may already be at capacity.
- If unable to secure appropriate storage (for example, power failure), the Home is responsible for contacting Simcoe Muskoka District Health Unit to receive further direction

TRACKING SYSTEMS

- The person responsible for receiving, storing and tracking the use of vaccines is the Infection Prevention and Control (IPAC) lead.
- On delivery, these supplies will be counted and signed for as per current practice.

PUBLIC HEALTH MEASURES

INTRODUCTION

Public health measures are non-medical interventions used to reduce the spread of disease. They include, but are not limited to:

- Providing public education;
- Issuing travel restrictions and screening travelers;
- Conducting case and contact management;
- Closing or restrictions on schools, businesses and facilities;
- Restricting public gatherings

Public Health Measures implemented in a pandemic may directly impact LTCSS operations as well as indirectly impact staff in their everyday lives.

The types of public health measures used during an influenza pandemic and their timing will depend on:

- The epidemiology of the virus (e.g. pathogenicity, mode/s of transmission, incubation period, demographic attack rate, period of communicability, susceptibility to anti-virals).
- The characteristics of the community (i.e. some measures, such as school closures, may be more effective in rural than urban areas).
- Public acceptance of the measures.
- The resources required to implement the measure. Some measures, such as tracing contacts and active surveillance, are labour intensive and may not be effective once the virus is widespread in the community.
- The amount of social disruption the measure will cause. For example, if the decision to cancel public transit services would be so disruptive, it is unlikely to be used. The decision to cancel sporting events or conferences could cause public panic. Social isolation measures that kept people home from work would be costly to businesses and could disrupt essential services.

OBJECTIVES

The public health measures objectives are:

- To decrease the number of individuals exposed to the novel virus and potentially slow the progress of the pandemic.
- To slow the spread of the disease and gain time for implementing medical measures (e.g. vaccine)
- To reduce the morbidity and mortality caused by the pandemic.

HEALTH UNIT RESPONSIBILITIES DURING PANDEMIC PERIODS

1. Institutional outbreak management and surveillance activities
2. Supporting disease assessment and treatment centres
3. Education
4. Communication, implementation of community-based public health measures

HEALTH UNIT SIGNAGE FOR LTCSS

During a Pandemic, LTCSS should utilize incident-specific signage provided by the SMDHU. Signs should be posted at entrances, in common areas, in elevators on the back of residents' doors for easy reference.
For more information on signage, see *Communications* section.

REQUIREMENTS IN ORDER FOR PANDEMIC TO BE DECLARED OVER

One incubation period plus one period of communicability for the pandemic strain is required from the onset of symptoms of the last case until the pandemic is declared over. This may be longer than the traditional 8-day period used for seasonal influenza.

Because LTCSS might have sporadic seasonal influenza activity during a pandemic, the Site Management Team may need to differentiate between seasonal and pandemic cases in declaring the end of the pandemic outbreak.

LTCSS COMMUNICATION WITH HEALTH UNIT

The Site Management Team will notify the SMDHU when the facility has completed the recommended length of time without a new case. The SMDHU will be responsible for declaring the pandemic over and for notifying the MOHLTC and other organizations in the community. This communication will include outbreak meetings with recorded minutes.

NATURAL DEATH SURGE PLANNING

Natural Death Surge: An increased number of deaths from natural causes that can occur over a period of time (weeks to months) rather than in one incident or event. The impact of an ongoing natural death surge may impact local systems and capabilities.

Multiple Fatality Event: An incident or event (usually a single event) where several persons die, and where the number of deaths exceeds the capabilities of the local resources

Death Surge in a Pandemic

A pandemic is more likely to produce a Natural Death Surge rather than a Multiple Fatality Event and therefore would not likely lead to an activation of the Provincial Multiple Fatality Plan, which is maintained by the Office of the Chief Coroner (OCC). The OCC may introduce expedited death response procedures in a disease outbreak as was implemented during the first wave of COVID-19 in the spring of 2020. Expedited death response procedures are designed to ensure that bodies are removed efficiently from health care facilities and to avoid straining the capacity of morgues.

In a pandemic, Long Term Care and Seniors Services will follow the direction of the Office of the Chief Coroner regarding the appropriate management of the death process (pronouncement, handling of the body, transportation, registration of death).

LTCSS PANDEMIC CONTROL MEASURES

RESIDENTS

1. Isolation and /or quarantine precautions may be initiated. Consideration should be given to the resident's current health and cognitive status and the risks associated with isolation.
2. Whenever possible, residents with symptoms should be in single rooms or co- horted in one unit. In those units, steps should be taken to avoid crowding. Contact with residents in the remainder of the home should also be avoided.
3. All necessary safety measures should be enforced to protect residents and staff from exposure.
4. LTCSS should collaborate with acute care hospitals, the local public health unit and Home and Community Care to make decisions about admissions and re- admissions during a pandemic. Decisions will be affected by resident needs, staffing levels, and the course of the pandemic.
5. If there is pandemic activity in the community but not in LTCSS, extra precautions will be used to ensure that no one exhibiting signs and symptoms of the pathogen is admitted to the home. All admissions to The LTCSS will be screened using the screening tool specific to the pathogen.
6. If there is insufficient staff this would be considered a reason not to admit.

7. If LTCSS have active cases, admissions and re-admissions will generally not be permitted, however this decision may be influenced by community needs. Factors to guide the decision are as follows;
    - The status of the pandemic
    - The residents health needs and the advice of the residents physician
    - Staffing levels
    - Access to prophylactics and therapeutics
    - the homes ability to provide appropriate accommodation and care services that require particular expertise (e.g. peritoneal dialysis, tube feeding)
    - the resident or their substitute decision maker has given informed consent
8. Non-urgent appointments should be rescheduled
9. Previously scheduled events (i.e. outings, celebrations. etc.) will be postponed when there is pandemic activity in LTCSS as all residents will be restricted to their assigned units.

STAFF/VOLUNTEERS

1. LTCSS will make every effort to deploy available staff/volunteer workers to ensure adequate levels of resident care. Utilization of temporary staff will be deployed in a similar manner.
2. Every effort will be made to notify staff and volunteers of any pandemic activity effecting LTCSS.
3. LTCSS will endeavor to support staff through the following;
    - Education
    - Access to PPE
    - Access to prophylactics, therapeutics and vaccines as determined by the MOHLTC/Simcoe Muskoka District Health Unit
    - Recognition of the tension between personal and professional responsibilities in an influenza pandemic
4. Staff/ Volunteer workers who develop signs and symptoms should report their illness to their supervisor/manager who will report to the Infection Control Lead.
5. Unless otherwise stated by the Public Health Unit, ill staff/volunteer workers will be excluded from work until they are fully recovered. The length of time of the exclusion will be determined by the Public Health depending on the epidemiology of the pandemic pathogen.
6. If the LTCSS find themselves in the situation of not having enough staff/volunteer workers to provide appropriate care, direction regarding safe return to work will be obtained from Public Health. Medical clearance for return to work will be provided by Public Health
7. The LTCSS will minimize the staff/volunteer workers movement between resident home areas, especially if some units are unaffected. Cohorting plans will be put into effect with regular auditing of compliance to these plans.

VISITORS

Visitor protocols during a Pandemic will be guided by evidence and direction from Public Health and Ministry of Long Term Care. They may include, but will not be limited to:

- Restriction on number of visitors
- Restriction on location of visits
- Restriction on length of visits
- Safety protocols required for visits (i.e. Limited contact with the resident, PPE required, articles that can be brought into the facility)

ASSESSMENT OF RESIDENT CARE NEEDS

OPTIONS FOR RESIDENT CARE

1. LTCSS should assess residents' care needs in order to identify, in the event of a pandemic activity in the community or home:
    - Residents who could be discharged temporarily to family members
    - Residents who could be discharged temporarily home with home care services
    - Residents who must continue to be cared for in a LTCH.
2. This information will be particularly important if hospitals are overwhelmed and LTCH beds are needed for patients convalescing, or in the event of staff shortages.

TRANSFERS

1. Transfers are likely to be restricted during a pandemic, and transfer procedures may change. LTCSS will use the following procedures unless informed otherwise:
    a. When any resident is to be transferred to the hospital during pandemic activity the hospital, the ambulance service, and PTAC (Provincial Transfer Authorization Centre) will be advised
    b. The hospital Infection Prevention and Control (IPAC) lead must be provided with the details of the case to ensure control measures are in place when the resident arrives at the hospital.
    c. Resident transfers to another LTC facility are not normally recommended during a pandemic. However, during a pandemic this policy may change in order to ensure residents receive appropriate care. The Medical Officer of Health or designate should be consulted regarding transfers

ALTERATIONS IN SERVICES

1. During a pandemic, LTCSS may reduce or delay some services to compensate for staff shortages, or to prevent the spread of illness.
2. Onsite adult day programs or childcare programs may be reduced or curtailed based on the capacity of the LTCH to staff them or due to public health measures implemented by the local Medical Officer of Health. There should be no interaction between ill residents and program participants. Program participants should be screened before entering the home.
3. Decisions about which services to reduce, curtail or enhance should be made based on nursing and professional judgment, residents' needs, infection control and prevention guidelines, and advice from the public health unit. Plans to reduce services should be discussed with Public Health and the Ministry of Long Term Care.
4. Services that should be considered for modification during pandemic activity include:
    - Medication Compression
    - Bathing Routines
    - Laboratory Services
5. Additional resident assessment may be required during outbreaks of pandemic activity related to pathogen, symptomology or unintended ramifications related to circumstances (i.e. social isolation)

GENERAL STAFF RESPONSIBILITIES DURING A PANDEMIC

During a pandemic, LTCSS staff are expected to adhere to the following:

- ✓ Ensure they familiarize themselves daily with the list of residents who are experiencing signs and symptoms of pandemic related illness and the precautions in place.
- ✓ Appropriate PPE (Personal Protective Equipment) use
- ✓ Posted isolation precautions
- ✓ Surveillance, screening and testing protocols
- ✓ All Public Health recommendations
- ✓ Infection Prevention and Control Practices
- ✓ Proper Hand Hygiene
- ✓ Reporting of any signs and symptoms of infection to they are experiencing to their Manager and Infection Control Lead.

ADDITIONAL PRECAUTIONS

Additional precautions, as well as routine practices are necessary to control the spread of certain pathogens. These precautions are based on method of transmission and are necessary for infections transmitted by the airborne or large droplet routes. They may be indicated for residents with certain highly transmissible or epidemiologically important microorganisms transmitted by direct or indirect contact.
Residents and their families should understand the nature of their infectious disease and the precautions being used, as well as the prevention of transmission of disease to family and friends.

The following factors must be considered:
Different organisms with different routes of transmission may infect residents with identical symptoms. For example, acute respiratory infections may be spread by large droplets alone (Pertussis) or large droplets and direct and indirect contact (respiratory viruses). Some microorganisms may be transmitted by more than one route, necessitating more than one type of transmission precaution e.g. Varicella (airborne and contact), Respiratory Syncytial Virus (RSV) (droplet and contact).

SIGNAGE

Signs can be used to alert staff, residents, and family members of a particular infection control situation. They can often include appropriate patient-care or visitation instructions. Signage outlining additional precautions that must be taken will be posted on the outside of the resident's room. And will include PPE necessary for entry to the room. Additional signage on the outside of the door will depict the appropriate donning of PPE. Additional signage on the back of the door will indicate appropriate doffing of PPE.

AIRBORNE PRECAUTIONS

1. Residents should be in a single room.
2. Wear an N-95 mask to enter the room.
3. Keep door and windows closed. Air from the room should be discharged outside the building and away from intake ducts, or through a high-efficiency filter if re-circulated
4. Wear an isolation gown for resident care activities/procedures if contamination or soilage is likely.
5. Wear gloves.
6. Perform appropriate hand hygiene
7. Articles contaminated with respiratory secretions should be disinfected upon leaving the room.
8. Resident should remain in the room. If necessary to leave the room, the resident must wear a surgical

mask when outside room.
9. Linen and waste can be removed from the room as per Routine Practices. If the outside bag has been contaminated, then double bag by the door upon removing it from the room.
10. Once the resident is off precautions an N-95 mask must be worn while the resident's room is being cleaned. The door should remain closed until the room is cleaned.
11. All persons susceptible to the specific disease should be excluded from entering the room if possible.

DROPLET PRECAUTIONS

1. Wear surgical mask.
2. Wear eye protection.
3. Wear gown.
4. Wear gloves as per Routine Practices.
5. Perform appropriate hand hygiene.
6. Room door may remain open.
7. Articles contaminated with respiratory secretions should be disinfected upon leaving the room.
8. Resident should remain in his/her room. If necessary to leave room, the resident must wear a surgical mask when outside the room.

CONTACT PRECAUTIONS

1. Wear gown if contamination is likely.
2. Wear gloves upon entering the resident's room.
3. Mask is not necessary.
4. Resident to remain in his/her room unless absolutely necessary to leave

ADDITIONAL CONSIDERATIONS

1. **Medical Equipment:**
   Electronic thermometers may be used; taking care to prevent contact with infectious material. When the electronic thermometer is removed from the resident's room it should be wiped down with a disinfectant wipe or other facility approved disinfectant. A thermometer that can be left in the resident's room for the duration of the isolation is preferable. Blood pressure cuff & Stethoscopes must be disinfected prior to using them on another resident. A blood pressure cuff and stethoscope that can be left in the resident's room for the duration of the isolation is preferable.

2. **Dishes:**
   Disposable dishes are not required or recommended for use with isolation precautions. Regular dishwashing cycles will clean dishes sufficiently. All used trays and contents may be returned to the Dietary Department with a minimal amount of handling. Any dishes visibly contaminated with blood or body fluids should be bagged before being sent to the Dietary Department. Rubber reusable gloves should be used to dismantle trays and to load dishes into the dishwasher. The dishwasher should be properly maintained and set at the temperature recommended by local Public Health Authorities

3. **Garbage:**
   Garbage soiled with blood or other body fluids may be sent to landfill provided they are well contained (e.g. bagged first in plastic bag) and provided your landfill site is in agreement. Alternatively, it may need to be placed into a designated lined box kept in the Soiled Utility Room. A licensed carrier should then remove the box, once sealed, from the site.

4. **Medical Equipment:**
   Electronic thermometers may be used; taking care to prevent contact with infectious material. When the electronic thermometer is removed from the resident's room it should be wiped down with a disinfectant wipe or other facility approved disinfectant. A thermometer that can be left in the resident's room for the duration of the isolation is preferable. Blood pressure cuff & Stethoscopes must be disinfected prior to using them on another resident. A blood pressure cuff and stethoscope that can be left in the resident's room for the duration of the isolation is preferable.

5. **Dishes:**
   Disposable dishes are not required or recommended for use with isolation precautions. Regular dishwashing cycles will clean dishes sufficiently. All used trays and contents may be returned to the Dietary Department with a minimal amount of handling. Any dishes visibly contaminated with blood or body fluids should be bagged before being sent to the Dietary Department. Rubber reusable gloves should be used to dismantle trays and to load dishes into the dishwasher. The dishwasher should be properly maintained and set at the temperature recommended by local Public Health Authorities.

6. **Garbage:**
   Garbage soiled with blood or other body fluids may be sent to landfill provided they are well contained (e.g. bagged first in plastic bag) and provided your landfill site is in agreement. Alternatively, it may need to be placed into a designated lined box kept in the Soiled Utility Room. A licensed carrier should then remove the box, once sealed, from the site.

7. **Hand Hygiene:**
   Hand hygiene is the removing/killing of microorganism on the hands and maintaining skin in good condition. Hand washing is considered to be the most important measure to prevent the spread of infection. Hand hygiene is the responsibility of all individuals. Hand hygiene products must be easily accessible at entrances to resident rooms, hallways and at entrances to buildings. Hand Hygiene is regularly audited in non-outbreak/pandemic times but increased auditing is performed during outbreaks or during pandemics to ensure staff are strictly adhering to the hand hygiene program.

8. **Personal Effects:**
   Resident clothing can be washed safely in the Facility using automatic washers, approved chemicals, hot water and normal drying cycles. Staff should bag clothes soiled with infective material while in the patient room using gloves.
   Personal items such as lotions, creams, and razors should not be shared with other residents.

PERSONAL PROTECTIVE EQUIPMENT AND MANAGEMENT

The protection of health care workers (HCWs), staff and residents continues to remain of paramount importance. Health care workplaces must adhere to requirements under the Occupational Health and Safety Act (OHSA) and its Regulations, and this applies to measures needed to protect workers from the risk of COVID-19. Directive #3, issued by the MOLTC on March 12, 2020, requires that all staff, essential visitors and caregivers follow universal masking requirements by wearing a procedure mask when in the Homes. PPE acquisition and distribution, including the calculation of burn rates, is managed corporately by a team comprised of staff from the corporate Procurement, Fleet and Property department and senior staff from LTCSS

PERSONAL PROTECTIVE EQUIPMENT (PPE) TYPES

Personal Protective Equipment (PPE) is used alone or in combination to prevent exposure by placing a barrier between the infectious sources and one's own mucous membranes, airways, skin and clothing. The selection of PPE is based on the nature of the interaction with the resident the likely mode (s) of transmission of infectious agents. The use of a Point of Care Risk Assessment enables staff to determine what type of PPE is required based on potential exposure to blood, body fluids, mucous membranes, non- intact skin, contaminated equipment and the condition of the resident. Even if the resident infectious status is unknown, the use of PPE is guided by the staff's observations of the resident's presentation and knowledge of modes of transmission.

Gloves

Gloves must be worn when it is anticipated that the hands will be in contact with mucous membranes, non-intact skin, tissue, blood, body fluids, secretions, excretions or equipment and environmental surfaces contaminated with any of the above.
Gloves are not required for routine health care activities in which contact is limited to intact skin.

a) Select appropriate glove size
b) Perform hand hygiene
c) Gloves should be put on immediately prior to the activity for which they are indicated
d) Gloves must be removed and discarded immediately after the activity for which they were used
e) Gloves should be removed or changed if moving from one contaminated body part to another and if in contact with a contaminated surface
f) Hand Hygiene is performed once gloves are removed
g) Do not wash or re-use gloves
h) The same pair of gloves should not be used for the care of more than one resident

Gowns

Gowns used as PPE should be cuffed and long-sleeved and offer full coverage of the body front, from-mid neck to mid-thigh or below. Lab coats are not considered a substitute for PPE gowns.

a) Gowns should only be worn when providing care for residents
b) When the use of a gown is indicated, the gown should be put on immediately before the task and must be secured at the top and around the waist
c) Remove gown immediately after the task for which it has been used in a manner that prevents contamination of clothing or skin and prevents agitation of the gown
d) Discard used gown immediately after removal. Do not hang gowns for later use
e) Do not re-use gowns
f) Do not go from resident to resident wearing the same gown

Masks

A mask (in addition to eye protection) is used to protect mucous membranes of the nose or mouth when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions, or within two metres of a coughing resident. A mask should also be worn for wound irrigation procedures if there is any risk of sprays or splashes.

a) Mask selection is based on a point of care risk assessment that includes the type and length of procedure and the likelihood of contact with droplets/aerosols generated by the procedure or interaction.
b) Masks should securely cover the nose and mouth and should be substantial enough to prevent droplet penetration

c) Mask should be changed if it becomes wet
d) Do not touch the mask while wearing it
e) Mask should be removed immediately after completion of the task and discarded
f) Do not allow mask to hang or dangle around the neck
g) Clean hands prior to application of and after removal of the mask
h) Do not re-use disposable masks
i) Do not fold or put masks into pockets for later use

N95 Respirators

An N95 respirator is used to prevent inhalation of small particles that may contain infectious agents transmitted via the airborne route.

a) An N95 mask is used in Long Term Care for the following aerosol generating medical procedures (AGMPs)
    - Nebulized medication
    - Caring for residents using CPAP devices
    - Caring for residents using high flow oxygen (>6 l/min)
    - Deep suctioning or tracheotomy care
    - Manual ventilation during CPR
b) N95 masks are not intended for extended wear and guidance of their use is provided as part of the outbreak protocols.
c) N95 masks are generally only indicated in the presence of an airborne infection (i.e.: Tuberculosis) and for staff caring for/providing treatment to a resident who requires an Aerosol Generating Medical Procedure (AGMP)
d) N95 masks are to be discarded after any contact with an isolated resident and prior to leaving a room where an AGMP is being performed
e) Refer to Mask Fit testing policy (IFC D-15) for information on mask fit testing requirements

Eye Protection

Eye protection is used (in addition to a mask) to protect the mucous membranes of the eyes when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions or when within two metres of a coughing resident. Eye protection should also be worn for wound irrigation procedures if there is any risk of sprays or splashes.

a) Eye protection includes:
    - Safety glasses
    - Safety goggles
    - Face shields
    - Visors attached to masks
b) Prescription glasses are not acceptable as eye protection
c) The choice of type of eye protection depends on the type and risk activity to be performed and the circumstances of exposure (droplet exposure versus splashes/sprays of fluid)
d) Eye protection may be re-used if they can be cleared between use;

Additional Considerations

- ✓ During an outbreak, PPE use will be directed through signage and communication by the IPAC Lead/designate dependent on the infections nature of the outbreak
- ✓ Education on the indications, rational and precautions for infectious disease and PPE is provided on hire and annually.

Mask Fit-Testing

1. All staff are required to have a current mask fit testing completed
2. A list of staff mask sizes will be kept on each nursing unit for ease of access to identify N95 mask needs on the unit.
3. All facial hair must be removed to ensure accurate fit with N95 masks

PERSONAL PROTECTIVE EQUIPMENT PROCESSES

INVENTORY LEVELS- PROCUREMENT

1. PPE Inventory at each Home will be determined based on Burn Rates that are calculated either daily during Outbreak, or weekly, when Home is not in Outbreak.
2. Inventory on hand at each Home will be kept to a minimum of 30 days and a maximum level of 60 days. Orders to Logistics for distribution will be based on these levels and directed by County PPE Lead.
3. Inventory on hand at Bradford Street Warehouse will be kept to a 60 day level based on non-outbreak burn rates. Procurement, Fleet and Property will source out and order according to these levels

PANDEMIC STOCKPILE

1. In 2020 a pandemic stockpile has been initiated. The size of the inventory in the Pandemic Stockpile is set to maintain 120 days worth of PPE and supplies based on outbreak burn rates.
2. The Procurement, Fleet and Property is responsible for sourcing, storing, and managing rotating supplies into regular LTCSS and Paramedic stockpiles to ensure adequate supply is maintained and supplies do not expire

LTCSS HOMES PPE INVENTORY COUNTS AND MANAGEMENT

Daily During Outbreak

- Access to the PPE storage room will be restricted
- PPE inventory counts are to be completed by 0900 daily.
- Complete the inventory sheet. The count will need to be in individual units, not by cases. Case sizes may change based on product availability.
- There should be no open cases in the room; once a case has been opened it is considered as having been removed from the stock and therefore “used”
- Once the inventory sheet is completed, send completed sheet to County PPE Lead

Weekly when not in Outbreak

- Environmental Services will be responsible for completing weekly counts on PPE on hand
- Inventories will be entered by Environmental Services into the Corporate Spreadsheet
- Burn Rates will be calculated weekly. Orders for distribution by Paramedic Services will be determined based on the weekly burn rates to a maximum of 60 days and a minimum of 30 days.

Inventory and Ordering Processes

- Burn rates of core PPE will be calculated daily using the current days inventory
- These burn rates will be used to ensure there is adequate stock on hand and will inform ordering. Weekly average burn rates will also be calculated
- If there is a request for a particular product, notify County PPE Lead who will liaise with PFP to ensure that items are obtained.
- Accurate inventory counts are essential to ensure that all PPE is available. We will be working to having 30 stock on site.
- Regular deliveries will be set up using Logistics from Paramedic Services.
- An email will be sent if we are made aware that a delivery is arriving.

Distribution Process

By 0900 - complete inventory of PPE room

- Designated supply rooms will be inventoried and stock dropped based on the current Transaction Log (attached)
- Check supply rooms and fill accordingly twice daily
- Filling of isolation carts will be completed by Home Area Staff (HSA) on an as needed basis from the stock in the designated supply cupboards based on specifications on isolation carts

Top: Permitted items only: Alcohol base hand rub (ABHR) and wipes
Drawer 1: Bouffant (20)
Drawer 2: Procedure/Surgical Masks (20)
Drawer 3: Face-Shields (10)
Drawer 4 (and if applicable drawer 5): Gloves

- Small (1 box)
- Medium (1 box)
- Large (1 box)

Drawer 6 (Bottom): Gowns (2 pkgs)

PPE TRANSACTION LOG

Supplies to leave in the service rooms on the wire racks to the following levels:

These levels will be determined by use/burn rate during an outbreak

Home Area 1		**Home Area 2**		**Home Area 3**	
Gowns		Gowns		Gowns	
Face Shields		Face Shields		Face Shields	
Masks		Masks		Masks	
Wipes		Wipes		Wipes	
Small gloves		Small gloves		Small gloves	
Medium Gloves		Medium Gloves		Medium Gloves	
Large Gloves		Large Gloves		Large Gloves	
XLarge Gloves		XLarge Gloves		XLarge Gloves	
Hand Sanitizer		Hand Sanitizer		Hand Sanitizer	

Home Area 4		Home Area 5		STAFF SCREENING	
Gowns		Gowns		Gowns	----------
Face Shields		Face Shields		Face Shields	:
Masks		Masks		Masks	
Wipes		Wipes		Wipes	
Small gloves		Small gloves		Small gloves	
Medium Gloves		Medium Gloves		Medium Gloves	
Large Gloves		Large Gloves		Large Gloves	
XLarge Gloves		XLarge Gloves		XLarge Gloves	
Hand Sanitizer		Hand Sanitizer		Hand Sanitizer	

STAFF AND RESIDENT COHORTING PLAN

LTCSS Centralized Scheduling and Operations Managers will work together to ensure that the staff and resident cohorting plan is followed during a pandemic.

Key Concepts

1. Residents from each cohort should be separated from residents in another cohort, for example:
    a. All residents of one unit considered a separate cohort and
    b. All residents in one unit cohorted according to pandemic illness status
2. Within an outbreak area, separate the:
    a. Exposed, well and not known to have pandemic illness cohort
    b. Exposed, ill but not known to have pandemic illness cohort

Known pandemic illness and infectious cohort

3. Staff members should be assigned to care for only one cohort unit and one cohort residents during the course of the outbreak if at all possible
4. Over the course of an outbreak, if possible, staff members should work with only one cohort, and not switch between cohorts
5. Staff working with one cohort should remain separate from staff members working with other cohorts if possible. It is very important for staff to stay at least two meters from each other at all times, including during breaks and meals
6. If staff must move between the cohorts, they should only go from the lowest risk cohort to the highest risk cohorts if at all possible, and not from high risk to low risk.

RESIDENT COHORTING PLAN

1. When a resident in a shared room becomes symptomatic with pandemic related illness, both residents are placed on appropriate precautions and tested/monitored appropriately.
2. The symptomatic resident's roommate will be moved to a private room on the unit if available, an unoccupied respite room, or to an appropriate unconventional space.
3. All rooms vacated by movement will receive a terminal clean.

4. If no private rooms or unconventional spaces are left available, residents of the same cohort will be moved together (i.e.: both residents are positive COVID or both negative but symptomatic).
5. Case by case considerations are made to move symptomatic residents in consultation with IPAC lead.
6. Ensure resident families are kept informed of changes to resident locations, including rationale for moves.

STAFF COHORTING PLAN

1. Direct Care Staff will be dedicated to one unit only
2. All staff are assigned by scheduling to a unit and will be given a visual identifierfor that unit by their respective manager.
3. Staff are expected to stay in that unit throughout the pandemic unless notified by CSS, RN or manager of a change
4. Staff will declare their unit assignment when screening into the Home at the beginning of their shift.
5. The screener will also ask staff to declare any movements from their assigned units at the end of the shift when the staff is leaving. These will be recorded on the staff's screening tool.
6. As part of PPE conservation activities, and unless directed otherwise by Public Health, not all PPE needs to be changed when working within a cohort.
7. If staff must move between cohorts, they should only move from the lowest risk cohort to the highest risk cohort. Uniforms must be changed in addition to all PPE and proper hand hygiene is performed.
8. Note: Safety overrides cohorting in emergency situations (i.e.: Fire, Code White)

PANDEMIC DIETARY SERVICES PLAN

In the event that a LTCH experiences a Pandemic, an Emergency Menu will be put into effect.

EMERGENCY MENU

1. A three (3) day rotating menu, including therapeutic and texture modified diets will be initiated.
2. Ministry of Long Term Care regulations will be adhered to as per nutritional quality and food safety.
3. Is a basic menu with limited choice
4. Frequent use of prepared / outsourced items
5. Only basic food preparation skills needed for majority of menu items
6. Menus is based on products that are already incorporated in the regular menu and can be rotated within normal menu cycles.
7. Assumes that staffing is limited but that electricity and water are available
8. Coffee, tea, milk, juice and water, bread, margarine and butter shall be provided at all meals as per the regular menu cycle.
9. At the time of the pandemic it will be determined where to feed residents in the unit dining rooms or their individual rooms. This decision will be based upon the ratio of healthy residents to sick residents and the number of staff available to supervise the residents while eating.
10. In the Event that the Food Services Department is short staffed
11. Menu revisions may be necessary in order to provide "Essential Services" only, meaning that the number of choices provided on the menu may be reduced.
12. LTCSS cannot guarantee that inventory will be available on all items; therefore some changes to the menu may be necessary during the course of the pandemic.

PANDEMIC AND OUTBREAK CLEANING PROTOCOLS

The home is cleaned in accordance with the Public Health Ontario's Best Practices of environmental cleaning for prevention and control of infections in all health care settings 3rd Edition (PIDAC).

The approach to cleaning will vary depending upon the area to be cleaned. For nonclinical areas such as lobbies and administrative offices, a "hotel clean" is required. Whereas resident home areas and clinical areas will require "healthcare" clean procedures.

AUDITING PROCESSES

1. In order to ensure that processes are understood, implemented and sustained, auditing and reporting processesand timelines will be required and reviewed monthly (pandemic vs. quarterly non-pandemic) by Performance, Quality and Development at home leadership meetings.
2. Audits can be both formal and informal. A formal audit is a standardized toolthat has been developed to evaluate a common policy, process or standard. Examples of formal audits include MOHLTC QIP audits, standardized internal audits (i.e.: HH/PPE) or audits that meet a program specific requirement. (i.e.: Admission Audits) Informal audits are those that test a small change being trialed as part of a change idea.
3. Audits are meant to evaluate a process and to be non-punitive in nature. Real time staff education by the auditor should occur when processes are not being adhered to throughout the audit
4. Audits are designed to ensure compliance with requirements such aspolicies, plans, procedures and applicable laws and regulations. They help determine whether the systems are adequate and effective in achieving goals and communicate the organizations efficiency in the use of resources.
5. All staff, in all departments within Health and Emergency Services, are responsible for continuous quality improvement activities, including completing and/or participating in service evaluations and auditing.
6. Routine audits are planned and scheduled annually by each departmental steering committee. These routine audits support evaluation of processes/policies
7. Other auditing activities support the following:
    - Evaluation of areas of legislative noncompliance and activities toachieve that compliance;
    - Sentinel or adverse events to help in determining root cause of event as well as contributing factors;
    - Audits that support effectiveness of a change idea;
    - Audits to determine or support cause of data results/variances;
    - Audits to ensure IPAC processes are followed
    - Audits to support the effectiveness and sustainability of initiatives (i.e.: Standard Work);
8. Audit findings will be addressed in the following manner:
    - ✓ In the moment coaching, re-education and discussions with staff will occur to assist with sustainable practice.
    - ✓ Review of roll-up of audit findings and actions at management meetings to identify any trends or consistent noncompliance that may require focused education or corrective action.
    - ✓ Review of audit findings at quarterly Professional Advisory Committee meetings and monthly Joint Health and Safety Committee meetings.
    - ✓ Review of audit findings with staff at unit huddles and departmental staff meetings for discussion and reinforcement of practices.
    - ✓ Review of audit findings at Departmental Steering Committee meetings as part of annual IPC program evaluation activities.

HAND HYGIENE AUDITS

1. Hand Hygiene audits are to be done throughout the year regardless of outbreak status in the Homes.
2. The guidance for auditing numbers for LTC/RH communities from Public Health is currently 56 audits per 100 beds. The frequency is increased internally during the traditional flu seasons (Sept-Mar) to daily to achieve ensure compliance is greater than 90%.
3. Hand Hygiene audits are completed on electronic tablets using Handy Audit tool

AUDIT SCHEDULE/FREQUENCY

An audit schedule will be developed by the operations team in consultation with the IPAC lead. Frequency of audits will be based on the following criteria:

1. Outbreak status of the Home
2. History of noncompliance
3. Audit finding trends

IPAC AND HEALTH AND SAFETY EDUCATION

Education content has been developed and delivered to support ongoing learning for the staff in the Homes. New Hire and Annual Education content has been revised to provide focused Infection Prevention Control and Health and Safety content to all staff including LMS modules and one-page quick reference tools.

A comprehensive PowerPoint education package specific to environmental services has also been developed and made available to all homes. Standard work has been completed for housekeeping, laundry and utilities roles.

HEALTH SERVICES

INTRODUCTION

The provision of health services during a pandemic could be the most challenging aspect of a pandemic response.

In the event of a pandemic, health care settings and providers will most likely need to reduce or stop some areas of services and program delivery in order to focus on and keep up with the demand for pandemic-related care. This will have a significant impact on health- care professionals in terms of job-related duties, hours of work, working conditions and worker health

OBJECTIVES

The health services objectives are:

- ✓ To ensure that all health services develop occupational health and infection prevention and control programs to protect workers.
- ✓ To identify the essential services to be provided during pandemic.
- ✓ To identify human resources required and how they will be deployed.
- ✓ To develop a system for purchasing, storing and distributing equipment and supplies.
- ✓ To develop a method to manage mass fatalities.

PANDEMIC RESPONSE

LTCSS' response to a Pandemic will be guided by the status of the pandemic worldwide as well as the level of the threat in the community. This will help ensure an appropriate level of response.

NO PANDEMIC ACTIVITY IN THE COUNTRY, PROVINCE OR COMMUNITY

1. If a Pandemic has been declared elsewhere in the world but there is no Pandemic Activity in the Country, Province or Community, LTCSS can continue to use a passive approach to surveillance which includes:
    - ✓ Allowing family members and visitors to self-screen
    - ✓ Looking for symptoms of the pathogen in residents while providing routinedaily care or activities
    - ✓ Staff reporting known symptoms to their supervisor/manager
2. Residents with symptoms should be noted on the daily surveillance form.
3. The surveillance form should be easy to use and include patient identification and location, date of onset of symptoms, a checklist of relevant signs and symptoms, diagnostic tests and results when available.
4. The completed surveillance form should be forwarded to the Infection Control Lead each day.
5. Any suspected pandemic activity should be reported immediately to the Infection Control Lead.

PANDEMIC ACTIVITY IN THE COUNTRY OR PROVINCE, BUT NO PANDEMIC ACTIVITY IN THE COMMUNITY

1. When there is pandemic activity in the country or province, LTCSS will take a more active approach to surveillance, including
    - ✓ Designate one entrance for visitors
    - ✓ Screen all visitors. This will be done by either staff or a volunteer
    - ✓ Actively seek out signs or symptoms in residents. LTCSS may utilize thefollowing methods:
        - Conducting unit rounds and consulting with staff
        - Review unit reports
        - Pharmacy antibiotic utilization rates
        - Lab reports
2. All available sources of information within the home may contribute to the surveillance activities.
3. The Infection Control Lead or designate will review the results of surveillance data for any signs of the pandemic pathogen.
4. At this stage in the pandemic, the Infection Control Lead will continue to use the normal reporting procedures to report to the local public health unit.

PANDEMIC ACTIVITY IN THE COMMUNITY

1. If the pandemic has spread into the community, the local public health unit will notify LTCSS.
2. LTCSS will:
    - ✓ Activate its pandemic plan
    - ✓ Activate the emergency plan if appropriate (e.g. if there is a loss of essential community services)
    - ✓ Maintain active surveillance, using pandemic reporting forms provided by local public health

PANDEMIC ACTIVITY IN THE LONG TERM CARE HOMES

1. When a pandemic of the pandemic pathogen is **suspected or confirmed** in LTCSS the following steps will be taken.
    - ✓ Implement pandemic management procedures (precautions and control measures) as per Infection Control Manual and direction from the Simcoe Muskoka District Health Unit
    - ✓ Utilization of a pathogen specific Pandemic Response Checklist to ensure that appropriate steps are taken.
    - ✓ Ensure all employees are notified quickly
    - ✓ Ensure necessary pandemic management supplies are easily accessible and well stocked
    - ✓ Reinforce the need for proper hand hygiene
    - ✓ Enforce appropriate use and removal of PPE by everyone providing direct care to ill residents
    - ✓ Distribute appropriate treatment and/or prophylactic medications if available
2. The Infection Control Lead or designate will contact the Medical Officer of Health or designate to report the potential or confirmed pandemic and submit the following:
    - ✓ Line list forms identifying residents/staff involved
    - ✓ Provide the name of primary Infection Prevention and Control (IPAC) lead and alternates with contact information.
    - ✓ Report on measures instituted
    - ✓ Request/receive investigation number (pandemic number)
    - ✓ Identify and collect diagnostic tests on those residents who fit the criteria for testing. Testing criteria will be determined by Public Health
    - ✓ The Infection Control Lead in conjunction with individuals that she/he might designate to assist will contact those individuals/organizations identified in a Pandemic Management Contact Checklist. This may include Ministry of Long Term Care, Ministry of Labour and any other organizations deemed necessary.

EMERGENCY RESPONSE

INTRODUCTION

Public health authorities will lead the response to an influenza pandemic. Health sector organizations and emergency responders will play vital roles in the provision of services and the coordination of overall emergency response.

Effective emergency response requires cooperation between many agencies to coordinate resources and services during all stages of an emergency. This chapter will describe the health and social infrastructures that will assist in pandemic influenza planning and response.

During the preparedness stages of an emergency, activities will include the development of plans and the conduction of simulation exercises to test these plans. It also includes the identification of communication systems and emergency management structures which will assist in local “readiness” to respond.

Contact information for key decision makers and essential service providers such as the health sector, emergency responders (such as police and firefighters), community services (such as utility and telecommunications workers), and social service providers will be identified to mount an effective response to an emergency.

To ensure that the consequences of a pandemic remain manageable, effective mitigation activities and resource allocation is required by those agencies responsible for providing services to the community. The Simcoe Muskoka District Health Unit has identified the approximate number and type of emergency responders and other essential service providers. It is imperative that these agencies develop business continuity plans to ensure the continued delivery of their services in the event of a pandemic.

Ongoing efforts are also required to ensure that health care organizations, essential service organizations, and other employers within Simcoe-Muskoka receive information about pandemic influenza, prevention and infection control strategies and business continuity planning. This information can be delivered via printed material, material posted on web sites, in person meetings, and group presentations/forums and workshops. The health unit will be working with municipalities and other community partners to ensure that these agencies have access to information on business continuity to assist them with their business continuity planning.

OBJECTIVES

The objectives of emergency response are:

- ✓ To ensure that effective emergency management structures are in place to allow for the collaboration between the health sector, emergency service personnel and public health to ensure that the planned pandemic response is coordinated
- ✓ To ensure a continuous state of readiness through education, testing and revision of plans
- ✓ To minimize societal and economic impacts by ensuring that emergency and essential services are maintained and
- ✓ Ensuring that effective communication systems are in place to facilitate information flow between the health unit, health sector and community emergency response partners.

SITE MANAGEMENT TEAM MEETINGS

When a pandemic or warning of an outbreak in LTCSS arises, the Incident Commander will establish a regular Operational Cycle meeting schedule with the Incident Management Site Team and supporting County of Simcoe Staff.

The frequency of these Operational Cycle meetings is set by the Incident Commander. These may be scheduled daily or less frequently as determined by the acuity of the situation. Operational Cycle will be held in the emergency command room at the LTCSS facility and will usually need to include a virtual option using the Virtual EOC meeting room for off-site support staff. (Reference: County of Simcoe LTCSS ERP and County of Simcoe ERP).
Site Management Team Operational Cycle Meetings will include:

- ✓ Status updates/situation report regarding the disease outbreak in the community or in the home.
- ✓ Review of any changes in case definition, ministry directives or required procedures from the Ministry of Health, Ministry of Long Term Care, Ontario Health and/or the Simcoe Muskoka District Health Unit.
- ✓ Review of the status of or changes to the control measures necessary to prevent the virus from spreading and confirm Infection Prevention and Control (IPAC) lead or designate who is responsible for ensuring that agreed upon control measures are in place and enforced, and for modifying control measures depending on epidemiology of the pandemic strain.
- ✓ Identify/confirm that the appropriate signage/information to be posted in the home and the appropriate locations.

- ✓ Institute exclusion policies and the staffing contingency plan
- ✓ Enforce proper use of PPE
- ✓ Implement LTC communication plan (see *Communications* section for further information)
- ✓ Clarify the role of the local public health unit and the availability of public health services, including lab testing. (Note: the level of public health assistance will depend on the extent of the pandemic activity in the community.)
- ✓ Determine the frequency that the Site Management Team will meet and schedule the next meeting.

POTENTIAL SHORTAGE OF HUMAN RESOURCES

LTCSS may experience staff shortages during a pandemic. This may result from staff being off sick, staying home to care for ill family members or being in required quarantine/self-isolation due to potential exposure. In an outbreak which is long in duration, there may be a loss of staff due to exhaustion or burnout.

LTCSS in partnership with the Human Resources department will take steps to maintain stable staffing levels in a pandemic through strategies such as staff redeployment, recruitment, and the use of community resources, agency staff, and in some cases health care or dietary students as required.

MEETING BASIC CARE NEEDS

- ✓ Cross train staff from support departments i.e. housekeeping, laundry, administration and environmental services to facilitate basic care needs. This training will commence once the pandemic influenza strains have been reported within the area.
- ✓ Training may be extended to volunteers that are willing to offer assistance should the need arise. Volunteers may also be utilized in non-care roles such as cleaning, food preparation, delivery and food serving with the proper emphasis on hand washing and general infection control practices.
- ✓ Department specific orientation programs will be utilized to train and/or cross train. These programs may require alteration dependent on the circumstances.
- ✓ Redeployed staff may be training to assist those providing care in the areas of feeding, bathing, transferring, turning and positioning.
- ✓ Staff, volunteers and family members assisting with direct care of residents will be supported by the Home in supplying the appropriate personal protective equipment for respiratory precautions or as directed by the Simcoe Muskoka District Health Unit.

CONTINUITY OF OPERATIONS PLAN (COOP)

Staffing shortages may necessitate the redeployment of staff to assist in LTCSS and other departments. The County of Simcoe Continuity of Operations Plan (COOP) serves as a reference document from this plan. The COOP contains procedures for identifying re-deployable staff, and the processes for requesting and redeploying staff to support other departments. This process is managed in coordination with the Finance and Administration Chief (HR) along with the Performance Quality and Development department.

Supporting Document: County of Simcoe Continuity of Operations Plan, 2020

COMMUNICATION

INTRODUCTION

Effective, accurate and timely communications provide the backbone for a coordinated response to an influenza pandemic. Communication is critical before, during and after an outbreak.

If a LTCSS home shows signs of going into an outbreak, there are required notification protocols for the Ministry of Long Term Care, the Simcoe Muskoka District Health Unit, Home and Community Care, hospitals who have admitted residents. This includes a Critical Incident System report must be completed and sent to the Ministry of Long Term Care.

The information needs of internal, external and stakeholder audiences have been assessed to determine the appropriate information processes and strategies that will be used for outbreak and pandemic communication. There is also a need for a high degree of coordination between LTCSS and County or external partners in the coordination of pandemic communications.

OBJECTIVES

The communication objectives are:

- ✓ To be sure that we are prepared to respond to public and provider communication needs
- ✓ To educate people about pandemic influenza and our plans to minimize the impacts
- ✓ To provide consistent, coordinated and effective communications
- ✓ To ensure that all health and emergency sector partners and the public have access to transparent, accessible, accurate, real-time information that will help them respond to challenges during each phase of the pandemic.

COMMUNICATION STRATEGIES

1. Different communications modalities will be used depending on the nature of the information and whether the audience is internal stakeholders, external stakeholders or both.
2. Internal communication is primarily for LTCSS residents, staff, volunteers and staff in supporting County departments.
3. External communication is directed to resident family members/next of kin, supporting partner agencies and the public in general.
4. Emergency information in a pandemic for LTCSS will be coordinated by the County of Simcoe Emergency Information Officer (EIO) using the Emergency Information and Crisis Communications plan from the County ERP.

TOOLS FOR INTERNAL COMMUNICATIONS

- ✓ email
- ✓ staff newsletters
- ✓ fact sheets
- ✓ County of Simcoe Intranet and LTCSS website
- ✓ staff information panels and computer screensavers
- ✓ town hall meetings (in-person or virtual)
- ✓ staff huddles

- ✓ signage/posters
- ✓ Send Word Now (for urgent communications)
- ✓ OTN

EXTERNAL COMMUNICATION STRATEGIES WITH RESIDENTS, FAMILIES AND STAKEHOLDERS

- ✓ family newsletters
- ✓ email
- ✓ LTCSS website
- ✓ Signage and posters at entrances
- ✓ town hall meetings (in-person or virtual)
- ✓ urgent communications may require direct phone calls with residents
- ✓ media releases

Information communicated must reflect up-to-date information in the LTCSS home and be consistent with Ministry of Health, Ministry of LTC, and Public Health messaging and directives

UPDATES AND AMENDMENTS

Original Simcoe Muskoka Pandemic Plan for Long Term Care	2009
T. DeVries-Porter, C. Simpson, R. Heffernan	December 2020
C. Simpson	February 2021
L. Garratt	July 2022