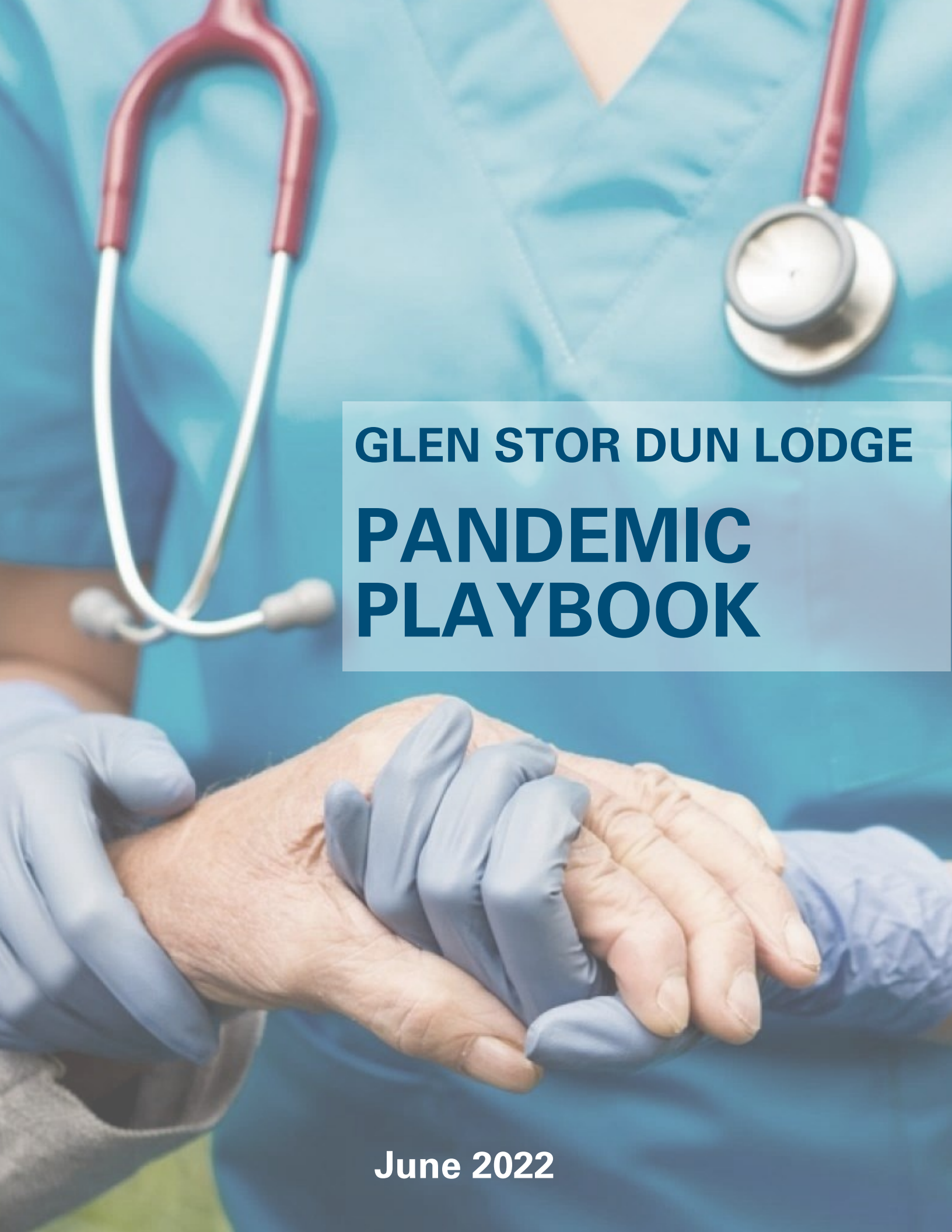


GLEN STOR DUN LODGE

PANDEMIC PLAYBOOK

June 2022

CONTENTS

1 PANDEMIC PLAYBOOK OVERVIEW

1.1 GLEN STOR DUN LODGE PANDEMIC PLAYBOOK

Glen Stor Dun Lodge is a non-profit municipal home for the aged, owned and operated by the City of Cornwall.

The Lodge opened in 1912 and has been located at its current site on the picturesque shores of the St. Lawrence River since 1952. In 1994 a completely new facility was constructed with considerable input from residents, clients, families, staff, volunteers and management. Glen Stor Dun Lodge provides support to citizens of the City of Cornwall and the United Counties of Stormont, Dundas and Glengarry in a smoke-free environment.

ABOUT THE GLEN STOR DUN LODGE

This 132-bed non-profit facility offers long-term care and outreach services to the citizens of our community. The Lodge building is a four-story custom-designed structure.

The ground floor consists of social amenities and community areas. The three upper floors are resident areas, with 108 private rooms, two of which are short-stay rooms, 12 semi-private rooms with two beds each, resident galleries, dining rooms, activity rooms and personal care areas. The special care unit houses 44 residents, divided into male and female areas. A special care garden, with a raised vegetable bed for a gardening program, is available for special care residents. Outdoor resident areas include a verandah and gazebo, which residents and families enjoy tremendously in the summer months.

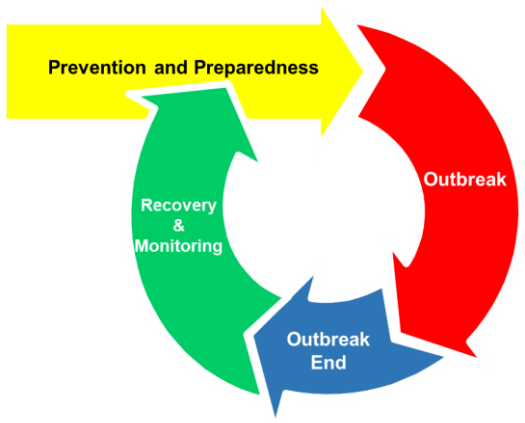
DEPARTMENT AND SERVICES

Glen Stor Dun Lodge, an accredited long-term care facility, provides a full range of services, exceeding the minimum standards set by the Ontario Ministry of Health and Long-Term Care. These services include dietary, housekeeping, laundry and maintenance, medical/nursing/physiotherapy services, recreation and leisure, religious and spiritual, and volunteer. Other services enhance resident quality of life: banking, hairdressing, postal and newsletter. Operations at the GSDL are supported by the following City's departments: HR Services, Financial Services, ITT Services, Purchasing Services, and Transit Services. (I added this part that is in red.)

The majority of Lodge staff members are permanently assigned to the same unit to enhance their relationship with residents and provide greater continuity of care.

1.2 HOW TO USE THIS PLAYBOOK

The GSDL Pandemic Playbook will assist the Home in making the best possible decisions in the context of a pandemic. The Playbook contains useful information about the pandemic, as well as steps the home should take to prevent and respond to an outbreak. Each section includes several checklists and templates that staff and managers can leverage to assess pandemic response in their area.



The approach to preventing and responding to a pandemic consists of four key phases:

- **Prevention and Preparedness:** Measures to prevent infection and prepare for a potential outbreak
- **Outbreak:** Measures to respond once at least one positive case is identified
- **Outbreak End:** Measures at the end of an outbreak to transition into recovery mode
- **Recovery and Monitoring:** Measures to ensure a gradual return to normal while working to prevent future outbreaks

This Playbook focuses mainly on the first two phases. The Playbook contains **general sections for Prevention and Preparedness and Outbreak Response** that should be distributed to all staff. All staff should be familiar with the contents of these sections and refer to them as appropriate. Note that measures introduced in Prevention and Preparedness will need to continue in Outbreak Response, unless otherwise specified.

The Playbook also includes a **function-specific section**, comprised of detailed checklists relevant to a specific function. These checklists are color-coded by prevention and outbreak measures. Staff should ensure they are familiar with the checklists relevant to their role.

1.3 PLAYBOOK SECTIONS

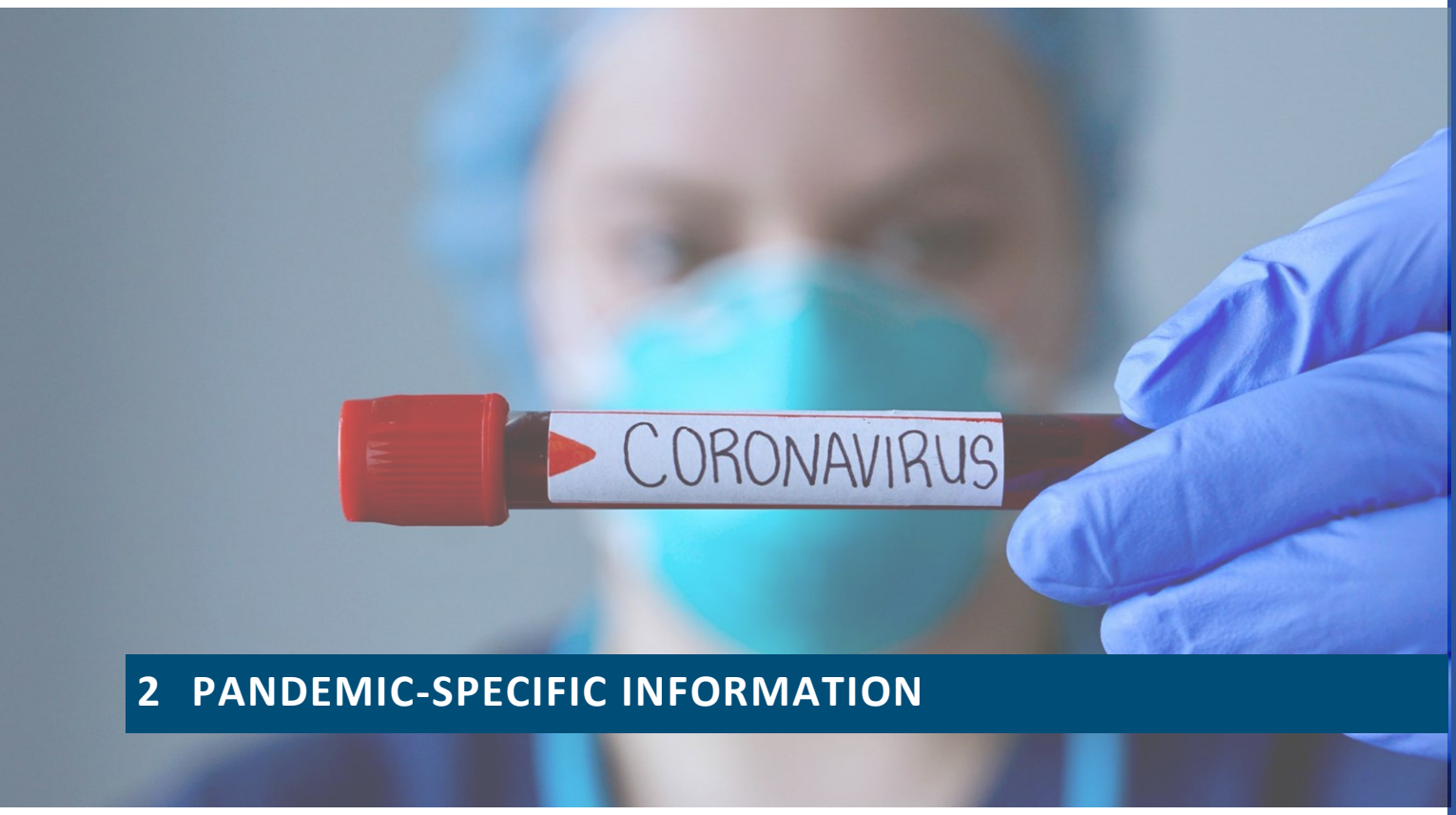
 PANDEMIC PLAYBOOK OVERVIEW	Key elements of playbook and tracking of updates
 PANDEMIC-SPECIFIC INFORMATION	Pandemic information including Case Definition and Symptoms
 POLICIES TO KNOW	Internal policies and Government / Public Health pandemic directives
 PREVENTION AND PREPAREDNESS	Prevention and preparedness measures applicable to all staff
 OUTBREAK RESPONSE	Outbreak management measures applicable to all staff
 RECOVERY AND MONITORING	Recovery and monitoring measures once an outbreak is declared over
 FUNCTION-SPECIFIC PROCEDURES	Detailed pandemic measures to put in place across all functions
 LEADERSHIP IN A PANDEMIC	Critical elements of leadership for all managers in a pandemic
 GOVERNMENT AND ADDITIONAL SUPPORT	Overview of external support, including additional staff from hospitals or the army
 EMERGENCY	Considerations for a potential emergency (fire, flood) during a pandemic
 TEMPLATES	Collection of templates, signage and tools used in a pandemic

1.4 UPDATES TRACKING

This Pandemic Playbook is an evolving document; as new information becomes available about potential pandemics, and new directives are issued by Public Health and Government authorities, changes should be made. The following table serves as a reference for changes made and enables users to quickly identify the changes made.

If you wish to request any updates to this Playbook, please email: _____

Revision Date	Section	Description of Revisions
Example 2020-05-01	*2.3.4 Example section*	*Example changes made to reflect example new government procedure*



2 PANDEMIC-SPECIFIC INFORMATION

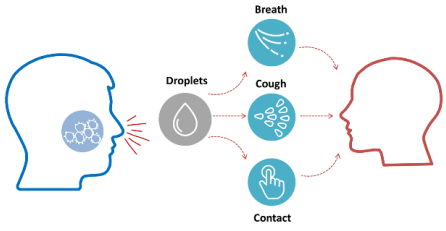
2.1 COVID-19 OVERVIEW

From the World Health Organization (WHO): "COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019." Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. The best way to prevent and slow down transmission is to be well informed about the COVID-19 virus, the symptoms it causes and how it spreads.

The virus is thought to spread mainly from person-to-person:

- COVID-19 cases and clusters demonstrate that **droplet/contact transmission** are the routes of transmission
- Most cases are linked to person-to-person transmission through close direct contact with someone who is positive for COVID-19
- There is no evidence that COVID-19 is transmitted through the airborne route

Coronavirus transmission is from human to human



The median incubation period of COVID-19 is 3 days. Allowing for variability and recall error and to establish consistency with the World Health Organization's COVID-19 case definition, exposure history based on the prior 10 days is recommended at this time.

Most people (about 80%) recover from the disease without needing special treatment. Around 1 out of every 6 people who gets COVID-19 becomes seriously ill and develops difficulty breathing. Older people, and those with underlying medical problems like high blood pressure, heart problems or diabetes, are more likely to develop serious illness. People exhibiting fever, cough and difficulty breathing should seek medical attention.

2.1.1 KEY SYMPTOMS

Some people become infected but do not develop any symptoms and don't feel unwell. Symptoms typically appear **2-3 days after exposure** and can range from mild symptoms to severe illness and death.

Common symptoms of COVID-19 include:
• Fever (temperature of 37.8°C or greater) • New or worsening cough • Tiredness • Shortness of breath (dyspnea) • New olfactory or taste disorder (decrease or loss of smell or taste)
Other symptoms of COVID-19 can include:
• Fatigue, lethargy, or malaise • Myalgias (muscle aches and pain) • Nausea, vomiting and/or diarrhea • Sore throat • Headache
Other signs of COVID-19 can include:
• Clinical or radiological evidence of pneumonia
Atypical symptoms/clinical pictures of COVID-19 should be considered, particularly in children, older persons, and people living with a developmental disability. Atypical symptoms can include:
• Unexplained fatigue / malaise / myalgias • Delirium (acutely altered mental status and inattention) • Unexplained or increased number of falls • Acute functional decline • Exacerbation of chronic conditions • Chills • Headaches • Croup • Conjunctivitis

- Multisystem inflammatory vasculitis in children
    - Presentation may include persistent fever, abdominal pain, conjunctivitis, gastrointestinal symptoms (nausea, vomiting and diarrhea) and rash

Atypical signs can include:

- Unexplained tachycardia, including age specific tachycardia for children
- Decrease in blood pressure
- Unexplained hypoxia (even if mild i.e., O_2 sat <90%)
- Lethargy, difficulty feeding in infants (if no other diagnosis)

Source: MOH, COVID-19 Reference Document for Symptoms, Version 8.0 – August 26, 2021

2.1.2 CASE DEFINITION

Probable Case

A person who:
Has symptoms compatible with COVID-19 (see footnote 9)
AND:

a. Traveled to, or from an affected area (including inside of Canada, see footnote 10) in the 14 days prior to symptom onset; OR
b. Had high-risk exposure (i.e., close contact) with a confirmed case of COVID-19 (see footnote 2), OR
c. Was exposed to a known cluster or outbreak

AND:

a. In whom a laboratory-based nucleic acid amplification test (NAAT)-based assay (e.g., real-time PCR or nucleic acid sequencing) for SARS-CoV-2 has not been completed (see footnote 13), OR
b. SARS-CoV-2 antibody is detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset (see footnote 11, 12).

OR

Has symptoms compatible with COVID-19 (see footnote 9)
AND
In whom a laboratory-based nucleic acid amplification test (NAAT)-based assay (e.g., real-time PCR or nucleic acid sequencing) for SARS-CoV-2 was inconclusive (see footnotes 4, 5), OR

Is asymptomatic
AND
Had high-risk exposure (i.e., close contact) with a confirmed case of COVID-19 (see footnote 2), OR
Was exposed to a known cluster or outbreak AND in whom a laboratory-based nucleic acid amplification test (NAAT)-based assay (e.g., real-time PCR or nucleic acid sequencing) for SARS-CoV-2 is inconclusive (see footnotes 4, 5);

OR

Is tested with a validated Health Canada-approved point-of-care (POC) NAAT for SARS-CoV-2 and the result is preliminary positive detected (see footnote 6)

Confirmed Case

- A person with confirmation of SARS-CoV-2 infection documented by:
  1- Detection of at least one specific gene target by a validated laboratory-based NAAT assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital or reference laboratory (e.g. Public Health Ontario Laboratory or the National Microbiology Laboratory) (see footnote 7, 8, 9).
  OR
  2- A validated POC NAAT that has been deemed acceptable by the Ontario Ministry of Health to provide a final result (i.e. does not require confirmatory testing) (see footnote 6).

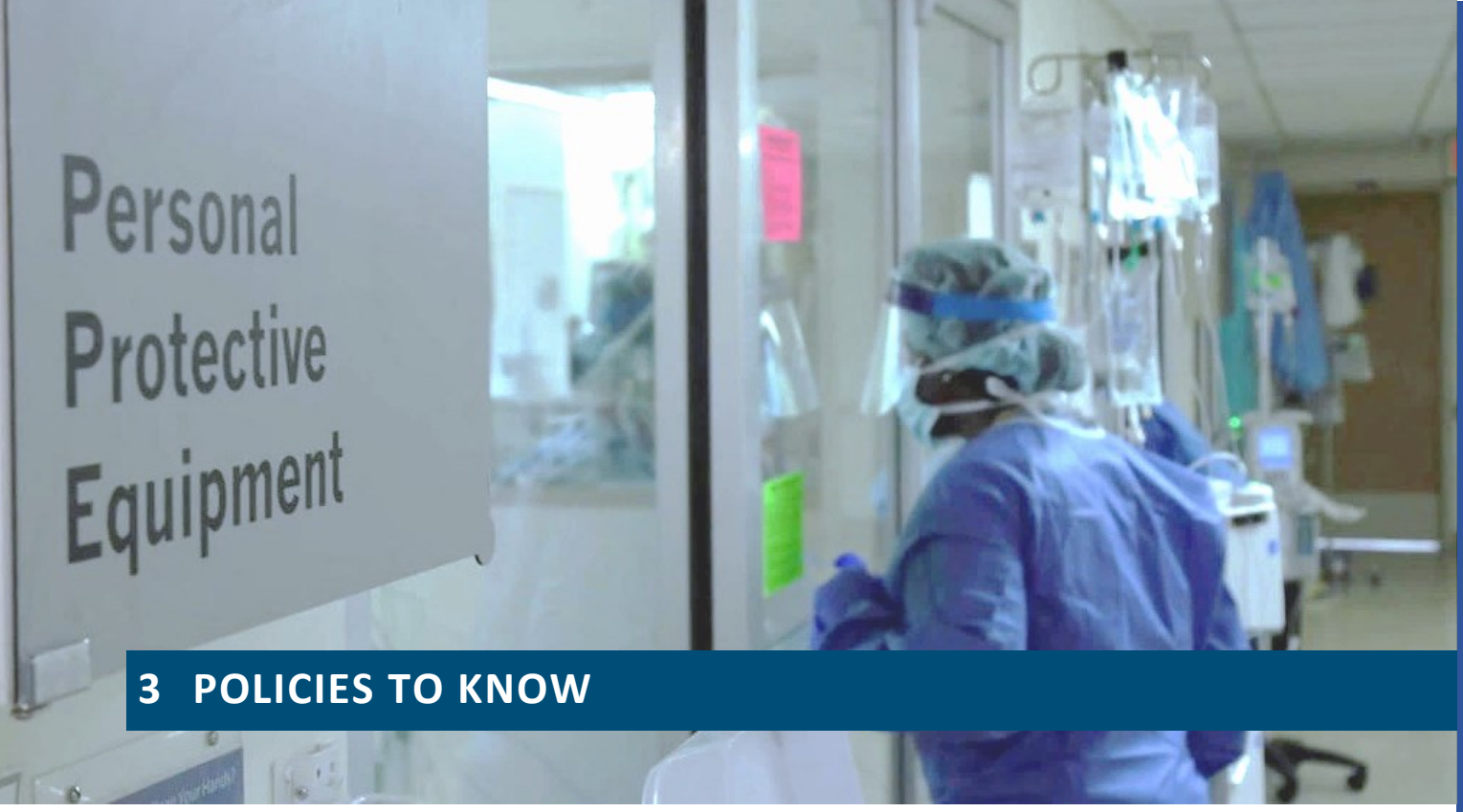
Footnotes

1. The median incubation period of COVID-19 is 3 days. Allowing for variability and recall error and to establish consistency with the World Health Organization's COVID-19 case definition, exposure history based on the prior 10 days is recommended at this time.
2. A close contact is defined as a person who had a high-risk exposure to a confirmed or probable case during their period of communicability. This includes household, community and healthcare exposures as outlined in Ministry guidance on cases and contacts of COVID-19.
3. Inconclusive is defined as an indeterminate result on a single or multiple real-time PCR target(s) and is not detected or remains indeterminate by an alternative real-time PCR assay, without sequencing confirmation, or a positive test with an assay that has limited performance data available.
4. An indeterminate result on a real-time PCR assay is defined as a late amplification signal in a real-time PCR reaction at a predetermined high cycle threshold (Ct) value range (note: Ct values of an indeterminate range vary by assay and not all assays have an indeterminate range). This may be due to low viral target quantity in the clinical specimen approaching the limit of detection of the assay, or alternatively in rare cases may represent nonspecific reactivity (false signal) in the specimen. When clinically relevant, repeat testing is recommended.
5. All positive results (preliminary and final) issued from molecular point-of-care assays are reportable to public health. Parallel/repeat specimens for confirmation through standard laboratory-based testing should be obtained for all preliminary point-of-care testing until further evaluation of their test performance. Final case status (Confirmed or Does Not Meet Case Definition) should be based on the confirmatory laboratory-based test result. If no parallel/repeat specimen is collected, the case status should remain as probable. Under specific scenarios (see Appendix 9: Management of Individuals with Point-of-Care Results or Point of Care Testing Use Case Guidance), final results can be issued from certain Ministry of Health approved point-of-care assays that have been evaluated, and do not require further testing for confirmation Additional testing may be recommended to guide case and public health management.
6. Information on symptoms compatible with COVID-19 illness and provincial testing guidance are available on the Ministry of Health's website.
7. Affected areas are updated regularly in the World Health Organization's Situation Reports. Current epidemiology in Canada is available through the Public Health Agency of Canada. For affected areas in Ontario, please refer to COVID-19 Response Framework: Keeping Ontario Safe and Open
8. COVID-19 antibody testing should not be used as an acute screening or diagnostic tool or used to determine a patient's immune status, vaccination status, or infectivity. Results should be interpreted in the context of the clinical and exposure history. Serology testing should not be used for patients who have been previously diagnosed with COVID-19 or who have received a SARS-CoV-2 vaccination.
9. Any case classified as probable based on a high-risk exposure (i.e. close contact) or exposure to a known cluster or outbreak, which subsequently tests negative/not detected for the SARS-CoV-2 virus

should no longer be classified as a probable case. Exceptions may be made for negatives on a compromised sample or if NAAT testing is delayed (e.g. >10 days following symptom onset), whereby such persons remain as probable cases.

10. When reinfection confirmation is based on detection of mutation(s) associated with a variant of concern (VOC) using VOC mutation real-time PCR testing in one of the infection episodes and not in the other episode, both specimens MUST have been screened for the same mutation(s) to ensure there has been a change in mutation status from one episode to the next

*Source: MOH, **COVID-19 Case Definition**, Updated May 21, 2021*



3 POLICIES TO KNOW

3.1 NEW DIRECTIVES MONITORING

The following resources should be monitored regularly and changes communicated accordingly. Best practice suggests appointing an office manager to read daily updates and report for DON / OMT / Administrator review. It is recommended to browse update dates on the page to quickly identify what has changed since last review.

#	Source	Link
1	MOHLTC	Guidance for Health Sector: health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx Directives and Memos: health.gov.on.ca/en/pro/programs/publichealth/coronavirus/dir_mem_res.aspx COVID-19 Information for the Long-Term Care (LTC) Sector: health.gov.on.ca/en/pro/programs/ltc/covid19.aspx
2	PHO	Daily Literature Scan: publichealthontario.ca/-/media/documents/ncov/ncov-daily-lit.pdf?la=en General information: publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus
3	EOHU	Region News and Statistics: eohu.ca/en/section/covid-19-updateshttps://eohu.ca/en/covid/important-covid-19-news-for-eohu-region Current Institutional Outbreaks: eohu.ca/en/my-community/current-outbreaks
4	ORCA	Directives tracker: docs.google.com/spreadsheets/d/13iWWfrNnVayNZMeTKwOiNrHLQFssfFh0HRvgOVht2iA https://docs.google.com/spreadsheets/d/13iWWfrNnVayNZMeTKwOiNrHLQFssfFh0HRvgOVht2iA/edit - gid=868345873
5	Ontario Government	Emergency Orders: https://www.ontario.ca/page/emergency-information
6	Government of Canada	COVID-19 updates signup: canada.ca/en/managed-web-service/get-updates-covid-19.html

#	Source	Link
7	OHA	Summary of legislative changes relating to COVID-19: oha.com/Bulletins/Summary%20of%20Legislative%20Changes%20Related%20to%20COVID-19.pdf

3.2 MANDATORY GOVERNMENT POLICIES AND GUIDANCE

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

Date	Description	Source
This list was last updated on 2-June-2020		
28-May-2020	COVID-19 Guidance: Congregate Living for Vulnerable Populations	MOH V1.0
28-May-2020	Update to COVID-19 Provincial Testing Guidance	MOH V5.0
28-May-2020	COVID-19 Quick Reference Public Health Guidance on Testing and Clearance	MOH V7.0
26-May-2020	Update to Directive #2: All deferred and non-essential and elective services carried out by Health Care Providers may be gradually restarted	MOH Directive #2
26-May-2020	COVID-19 Operational Requirements: Health Sector Restart	MOH V1.0
25-May-2020	Update to Reference Document for Symptoms	MOH V5.0
24-May-2020	Updated testing strategy: asymptomatic individuals who may have been exposed through their employment cannot be refused testing	MOH Memo
23-May-2020	Update to MOH Directive #3: Permit share IPAC assessment with several stakeholders	MOH Directive #3
21-May-2020	Update to MOH Directive #3: Only re-admissions from hospitals (no admissions); Permit IPAC assessment	MOH Directive #3
17-May-2020	Update to COVID-19 Patient Screening Guidance Document	MOH V3.0
14-May-2020	~~Update to Reference Document for Symptoms~~	MOH V4.0
14-May-2020	~~Update to COVID-19 Provincial Testing Guidance~~	MOH V4.0
12-May-2020	Order regarding Management of LTCH in outbreak	O. Reg. 210/20
11-May-2020	~~Update to Reference Document for Symptoms~~	MOH V3.0
6-May-2020	Update to COVID-19 Screening Tool for LTCH	MOH V3.0
2-May-2020	~~Update to Reference Document for Symptoms~~	MOH V2.0
2-May-2020	~~Update to COVID-19 Patient Screening Guidance Document~~	MOH V2.0
2-May-2020	~~Update to COVID-19 Provincial Testing Guidance~~	MOH V3.0
15-Apr-2020	COVID-19 Action Plan: LTCH	MOH V1.0
15-Apr-2020	COVID-19 Guidance: Long-Term Care Homes	MOH V4.0
15-Apr-2020	Outbreak assessment, testing and handling positive cases	MOH Directive #3
15-Apr-2020	Food and product deliveries dropped in an identified area; active screening of delivery personnel prior to entry	MOH Directive #3
15-Apr-2020	Staff and resident cohorting	MOH Directive #3
15-Apr-2020	Staff and essential visitor masking at all times	MOH Directive #3
15-Apr-2020	Isolation, testing and contact and droplet precautions for all admissions and re-admissions	MOH Directive #3
15-Apr-2020	Active screening of all staff, essential visitors, all others entering the home twice daily including temperature check (emergency responders excepted)	MOH Directive #3
15-Apr-2020	Suspension of transfers from hospitals	MOH Memo
10-Apr-2020	Update to Directive #5: Detail on PPE stewardship	MOH Directive #5

Date	Description	Source
30-Mar-2020	Contact and droplet precautions for all interaction with suspected, presumed or confirmed COVID-19 patients; airborne precautions for droplet generating procedures	MOH Directive #1
30-Mar-2020	PPE requirements and preservation	MOH Directive #5
27-Mar-2020	Reporting of PPE inventory	HPPA Order
22-Mar-2020	Short-stay absences not permitted	MOH Directive #3
22-Mar-2020	Limit number of work locations	MOH Directive #3
21-Mar-2020	EMCPA Order to take any reasonably necessary measures to respond to and prevent outbreak	O. Reg. 74/20
19-Mar-2020	Physical distancing in the workplace	MOH Memo
19-Mar-2020	Cease non-essential travel and self-isolate for 14 days after travel outside Canada	MOH Memo
17-Mar-2020	Streamlining of requirements for LTC including reporting, documentation, staffing / easing of hiring requirements, etc. (expires May 19, 2020 unless extended)	O. Reg. 95/20
14-Mar-2020	Entry of non-essential visitors not permitted (essential visitors only)	MOH Directive #3
12-Mar-2020	Active screening of all visitors, resident admissions, re-admissions, returning residents and staff	MOH Memo
9-Mar-2020	~~Screening of all visitors, resident admissions, re-admissions and returning residents; self-screening for staff, students and volunteers~~	MOH Memo

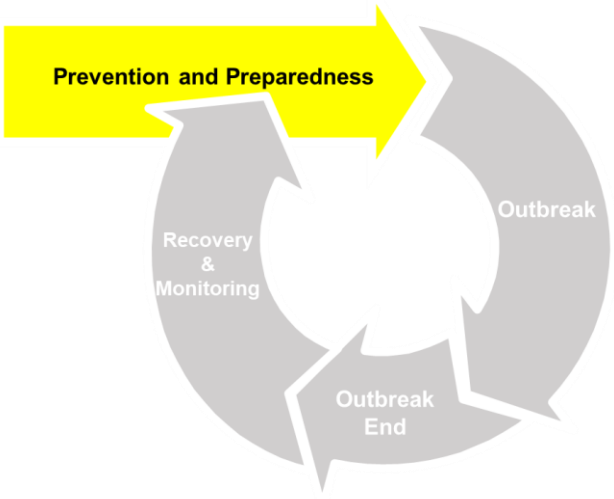
3.3 OUR INTERNAL POLICIES

In addition to this Pandemic Playbook, all staff and management should be familiar with and apply Glen-Stor-Dun Lodge's existing policies, including, but not limited to, the following policies:

- ☐ 1007-01 Outbreak Definition Other Communicable Disease (*link*)
- ☐ 1007-02 Outbreak Contingency Plan (*link*)
- ☐ 1007-03 Visiting Routines (*link*)
- ☐ 1007-03A Outbreak Recognition (*link*)
- ☐ 1007-03B Outbreak Management Team (*link*)
- ☐ 1007-03C Outbreak Notification Lists (*link*)
- ☐ 1007-03D Communication Regarding Outbreaks (*link*)
- ☐ 1007-03E GSDL Specific Pandemic Plan (*link*)
- ☐ Infection Control and Prevention (*link*)
- ☐ Hand hygiene / Respiratory hygiene (*link*)
- ☐ Dining (*link*)
- ☐ Laundry (*link*)
- ☐ Cleaning and Disinfection (*link*)
- ☐ Reception of goods *(link)*
- ☐ Admissions (*link*)
- ☐ Existing daily tasks per department / checklists (*link*)

The contents of this Pandemic Playbook should take precedence over existing policies; for any gaps not addressed in this playbook, refer to existing policies.

4 PREVENTION AND PREPAREDNESS



This section outlines the best practices and guidelines all staff should be familiar with to prevent and prepare for an outbreak during a pandemic.

It is important to note that prevention and preparedness measures will stay in place if an outbreak is declared.

This chapter is intended to be shared with the entire long-term care home team to ensure there is a broad awareness of all Prevention and Preparedness measures.

See PHO Checklist for COVID-19: Infection Prevention and Control for additional information and updates.

4.1 SCREENING

All LTCH must undertake screening of all residents, staff and essential visitors, or anyone entering the facility at all times. Screening is one of the key prevention measures in ensuring diseases are not brought into the facility. Careful selection and training of screeners is critical in ensuring the safety of all.

4.1.1 ACTIVE SCREENING

#	Steps to implement	Done
1	**All individuals entering the facility should be screened, seven days a week 24 hours a day,** including staff, essential visitors, suppliers, etc. Entry cannot be granted without screening. The screener must: • **Log all entries** to the facility • **Ask about symptoms** including fever, cough, difficulty breathing, runny nose, sore throat, headache, muscle aches, diarrhea • Ask about potential **close contact** with symptomatic or infected individuals* A screening tool has been created by the MOH (see template). Anyone who does not pass a screening will not be allowed to enter, should self-isolate and contact their managers. Note: Emergency first responders should be permitted entry without screening	
2	The facility should **designate a screener at all times**. During busy times (e.g. beginning of shifts), the screener should be at the entrance. Outside those times, alternatives can be used to call the screener to the door, but the doors should be locked or monitored (e.g. call button, phone number to call for someone to come to the door, etc.).	
3	All residents are to be screened **twice daily**, including temperature checks. Log in PCC (or template if PCC not used).	
5	Staff, volunteers, and essential visitors should **self-assess** if they believe they may have been infected. Self-assessment tool: https://covid-19.ontario.ca/self-assessment/	
6	A **central record of all screenings** should be maintained and **reviewed by management daily.** See sample templates	
7	Screener should **wear at a minimum mask, eye protection and gloves** or be behind plexiglass partition, and have access to alcohol-based hand rub	
8	**Failed screening: Isolate / Do not allow to enter the home and handle as suspected case (see section Suspected Case)**	

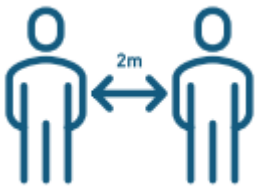
Close contact *is defined as a person who* ***provided care*** *for the individual, including healthcare workers, family members or other caregivers, or who had* ***other similar close physical contact*** *(e.g. shaking hands, face-to-face contact within 2 meters and greater than 15 minutes, coughed on) or who* ***lived with*** *or otherwise had* ***close prolonged contact*** *(e.g. in a close environment such as a meeting room or hospital waiting room, in an aircraft sitting within two seats) with a probable or confirmed case of COVID-19 while the person was ill.*

4.1.2 PASSIVE SCREENING AND SIGNAGE

#	Steps to implement	Done
1	Signage across the home: • Reminders to perform hand hygiene • Reminders to follow physical distancing etiquette • Reminders to follow respiratory etiquette • Signs and symptoms of COVID-19 • Steps that must be taken if COVID-19 is suspected or confirmed in a staff member or a resident • PPE donning and doffing visuals, as well as disposal instructions • PCRA reminders at each room • Display reminders and information on TV monitors in each home area • Visual reminders to perform point of care risk assessment (PCRA) prior to any resident interaction (recommend having at medcarts, nursing stations, computers, entry of each home area)	
2	Signage at entrances: • Indicates building access directives • Symptoms of COVID-19 and reminder not to enter the LTCH if presenting any (symptoms), go home and isolate / get tested • Reminders of precautions for staff outside the home (See SIGNAGE: PRECAUTIONS OUTSIDE THE HOME)	
3	**Physical distancing signage** and markers (e.g. footprints every 2m, tape lines on the floor) available in areas where staff or residents tend to congregate (e.g. break areas, nursing station, computers, building entrance, etc.) Note: Several kits available online from different providers (Example)	
4	Elevator signage to indicate maximum occupancy for physical distancing	
5	Floor markers to indicate paths for clean and soiled laundry, PPE, etc. to avoid mixing both	

4.1.3 PHYSICAL DISTANCING

Physical distancing means maintaining a **minimum distance of 2 meters** from other individuals at all times to minimize close contact and transmission of diseases. Some routine changes may be required to apply physical distancing:



- Avoid handshakes
- Avoid crowded places and non-essential gatherings
- Limit contact with people at higher risk
- Keep 2 arm lengths from others (approximately 2m)

4.2 CLEANING AND DISINFECTION

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

#	Steps to implement	Done

1	**Hand hygiene** should be performed frequently:
	• 4 moments of hand hygiene
	  ○ Before initial patient / patient environment contact
	  ○ Before aseptic procedure
	  ○ After body fluid exposure risk
	  ○ After patient / patient environment contact
	• When entering and exiting the home
	• Whenever moving from one resident room to another
	• Before performing soiled cleaning functions
	• Before preparing, handling, serving, or eating food
	• Before and after engaging in group activities
	• Before and after coffee / meal breaks
	• After washroom breaks
	• After sneeze
	• Before and after putting on gloves / PPE
	See Public Health Ontario Video on handwashing: https://youtu.be/o9hjmqes72I
	See Public Health Ontario Video on handrubbing: https://youtu.be/sDUJ4CAYhpA	

2	All staff should be familiar with and apply standard **Infection Prevention and Control measures**. If any staff would like a refresher training, they should reach out to the home's IPC Officer	
3	Staff should **assist residents in performing hand hygiene**: • Before / after meals • After contact with bodily fluids (cough, sneeze, bathroom) • Before / after leaving room • Before / after group activities	
4	Notify environmental staff if **hand hygiene products run out**	
5	All mobile or shared equipment (e.g., carts, trolleys, wheelchairs, commodes, pumps, and poles) should be **cleaned and disinfected between each resident use**. All staff should follow environmental processes put in place to ensure no equipment is reused without being cleaned; this may include designing separate areas for clean and dirty equipment, using visual cues / signs to identify dirty vs. clean equipment, having staff clean the equipment after each use, etc.	
6	**Soiled linen** should never come in contact with clean linen or surfaces that have been in contact with soiled linen. All staff should follow environment processes to avoid contamination. All soiled laundry should be considered potentially infectious.	
7	All **high touch areas** should be disinfected with increased frequency / after use (e.g., elevator buttons, bed ramps, stairs, etc.)	

The below products are recommended for cleaning and disinfection during the pandemic, including kill-times (i.e. time that all disinfecting products need to stay wet on the surface to kill bacteria and viruses). Staff should know and follow manufacturers' instructions for all products they use.

Product and use		Kill time / Contact Time
	Brand: *Oxivir TB* Purpose: Disinfection of all areas	1 MIN
	Product: PerCEPT Disinfecting Cleaner Purpose: Disinfection of all areas	5 MIN

The following products are **not recommended** for use in long-term care during pandemics:

Product and use		Kill time / Contact Time
	Quaternary Ammonium	10 MIN
	Lysol Disinfecting Wipes (All Scents)	10 MIN
	Lysol Disinfectant Spray	10 MIN
	Clorox Performance Bleach 1 and 2	10 MIN

Source: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

4.3 MASKING, PPE AND OTHER SUPPLIES USE

#	Steps to implement	Done
1	Staff should receive **training on PPE use** and proper donning / doffing procedures.	
2	**Masks:** Long-term care homes should immediately ensure that **all staff** wear surgical/procedure masks at all times. This is required for all homes; those in outbreak and those not in outbreak. Masks should be placed near the entry to the home. • Masks should be **replaced if they become soiled or moist** (e.g. when sneezing), or after interacting with a resident with a suspected or confirmed case • For staff who are taking breaks, the surgical/procedure mask may be removed but a minimum two-meter distance should be maintained from others • **Residents** do not require masks at this time (they should be given a mask if going out for appointments / hospital, or if being moved within the facility and suspected or positive) • **Essential visitors** must also wear a surgical/procedure mask at all times while in the home – visitors should bring their own surgical masks	
3	All staff should have undergone **N95 fit** testing	
4	**PPE: Contact and Droplet Precautions** require PPE. Contact/Droplet precautions PPE should be available outside isolation rooms (and units where appropriate) and used when providing care to a resident **suspected or confirmed** of having contracted the disease. Contact/Droplet precautions PPE includes: • Surgical/procedure mask • Goggles or Face shield • Gown • Gloves	
5	For aerosol generating medical procedures (**AGMP**), Airborne precautions should be taken, which include **Contact/Droplet precautions PPE and N95 respirators** (instead of surgical mask)	
6	Proper **receptacles** (no touch ideally) should be put in place to gather used PPE inside the isolation room near the exit and across the home, and no PPE is to be reused in a separate room.	
7	When Droplet and Contact precautions are in place (suspected or confirmed cases), **condense resident care** where possible to reduce resident touchpoints and limit PPE use (e.g. screening with morning care)	
8	Assess **PPE** requirements based on resident touchpoints. See CDC's PPE burn rate calculator or NIOSH PPE Tracker app	
9	Procure a minimum of **14-day supply of PPE** on an ongoing basis. In prevention, PPE levels are recommended to be sufficient for 14 days of outbreak measures in one unit. Once in outbreak, procure 14-day supply for all units in outbreak. Note: This may require a dedicated role as shortages are widespread. Several suppliers should be identified, and orders may need to be placed for several months in the future. Communicate with vendors when in outbreak as they may be able to prioritize orders.	
10	Implement process for **tracking of PPE availability** • Option 1: Have staff submit daily count of PPE used and tally for entire facility • Option 2: Keep count of PPE levels in storage and update as supplies are restocked / used	

#	Steps to implement	Done
	Report PPE levels to authorities as required.	
11	PPE should be **stored in a secure location** to avoid theft and unnecessary use	

Note: PPE may frighten residents, particularly those who are cognitively impaired. Staff can introduce themselves at the resident's doorway prior to donning and notify the resident that they will be entering the room with a face shield and gown. More detailed guidance can be found here: https://www.rgptoronto.ca/wp-content/uploads/2020/05/Person-Behind-the-Mask-for-LTC.pdf

All staff should be trained on **donning and doffing procedures** as outlined below, and signage should be placed near donning / doffing stations to remind staff of steps. Regular audits and refresher training should be performed throughout a pandemic. A more detailed guide is included in templates, and PHO Videos can be found here:

- Donning (https://www.youtube.com/watch?v=s2z1uM1fXN8)
- Doffing (https://www.youtube.com/watch?v=crGlUX3_4DA)

4.3.1 PPE USE BY ROLE

	Entering room of Suspected or Positive Resident / Resident in Outbreak area or home					In non-Resident area/ Negative Resident Room				
Role	**Mask**	**N95**	**Gown**	**Gloves**	**Eye protection**	**Mask**	**Gown**	**Gloves**	**Eye protection**	**N95**
Health Care Worker* (Clinical/Care)	✓	✓	✓	✓	✓	✓				
Cleaning / Janitorial staff	✓	✓	✓	✓	✓	✓		✓		
Laundry staff**	✓	✓	✓	✓	✓	✓	✓ When handling soiled laundry	✓ When handling soiled laundry	✓ When handling soiled laundry	
Dining staff	✓	✓	✓	✓	✓	✓				
All other staff*	✓	✓	✓	✓	✓	✓				
Administrative staff	✓	✓	✓	✓	✓	✓				
Screener	N/A	N/A	N/A	N/A	N/A	✓			✓	
Essential Visitors	✓		✓	✓	✓	✓	If possible	If possible	If possible	

*Please note that if unit cohorting is in place (both for residents and staff), any staff member acting as an expert and entering a unit / home area to which they are not assigned should use contact and droplet precautions at all times.

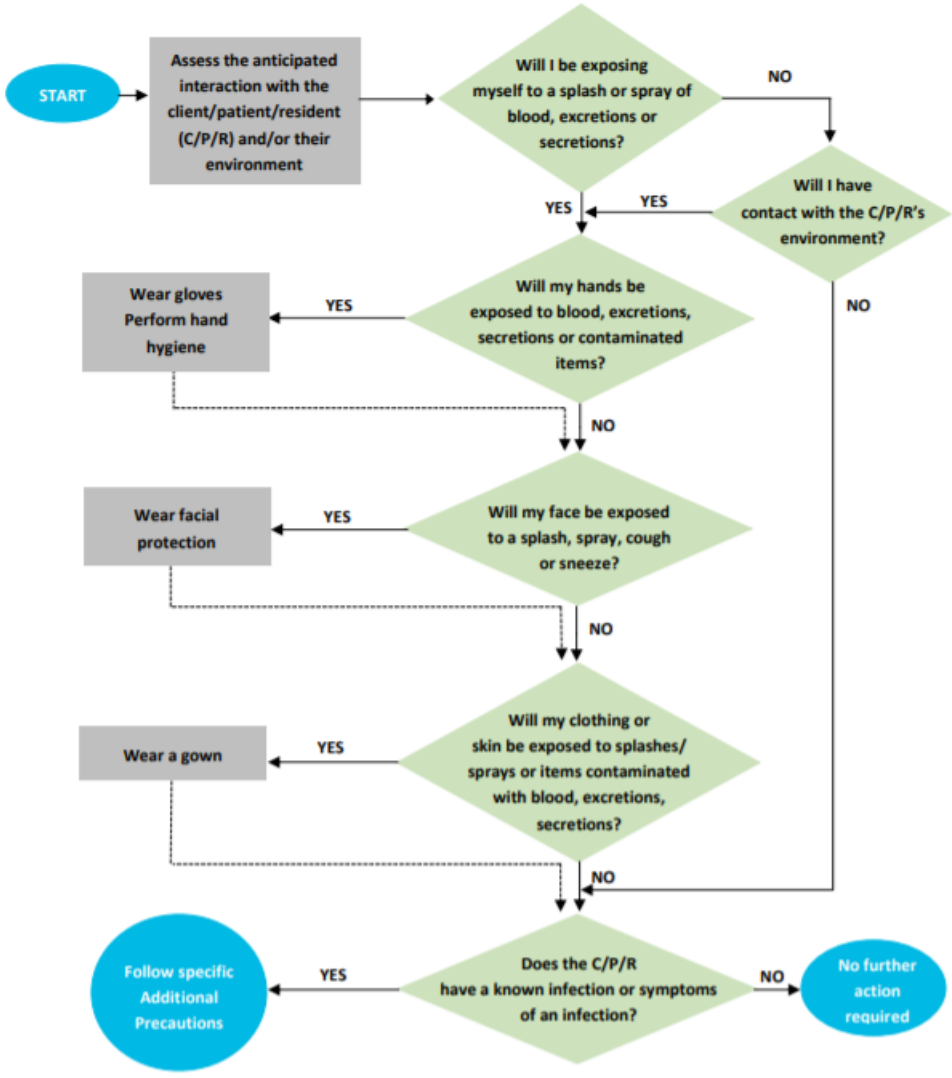
**Please note that Laundry staff should wear mask, gown, gloves, eye protection and a plastic apron when handling soiled laundry or in the soiled laundry section.

4.3.2 POINT-OF-CARE RISK ASSESSMENT (PCRA)

A point of care risk assessment (PCRA) **assesses the task, the resident and the environment**. A PCRA is a dynamic risk assessment completed by the staff member **before every resident interaction** to determine whether there is risk of being exposed to an infection.

Performing a PCRA is the first step in Routine Practices, which are to be used with all patients, for all care and interactions. A PCRA will help **determine the correct PPE** required to protect the health care worker in their interaction with the patient and patient environment.

POINT-OF-CARE RISK ASSESSMENT (PCRA) SAMPLE FLOWCHART



Source: PHO, https://www.publichealthontario.ca/-/media/documents/r/2012/rpap-risk-assessment.pdf?la=en

4.3.3 PPE CONSERVATION: EXTENDED USE AND REUSE

PPE shortages may occur in pandemics. If the home is experiencing shortages, they may choose to implement the following conservation measures. Note that these are not standard practices for PPE and should not be used unless there is a shortage. **Always follow direction from IPAC Officer or designate when it comes to PPE conservation**.

PPE	Conservation Measure	Done
Surgical mask	• As long as masks are not soiled, wet or dirty, they can be worn to provide care to several residents (extended use) • Masks should be changed when soiled, or when moving between COVID-19 positive/suspected residents and other residents •	

PPE	Conservation Measure	Done
Eye protection	• As long as eye protection is not soiled, wet or dirty, it can be worn to provide care to several residents (extended use) – note that eye protection is generally not required when not in outbreak • Eye protection should be changed when soiled, or when moving between COVID-19 positive/suspected residents and other residents • Reusable eye protection requires no extended use measures – it should always be washed and disinfected between uses • Some disposable eye protection may be reused, but should be reused by the same staff member and washed and disinfected between uses (recommend writing names of staff on shield in permanent marker) • Some face shields with soft foam parts should only be washed on the plastic part as the foam will get damaged if washed • Once visible damage appears on a reusable shield, it should be disposed of	
Gloves	• Gloves should never be reused between residents and should be disposed of after use	
Gowns	• Gowns should be changed between each resident • Reusable gowns should be washed between each use • Disposable gowns can generally not be washed and should be disposed of after use • If necessary, one gown can be used for multiple confirmed positive residents	

4.4 COHORTING

Cohorting refers to all activities related to grouping staff and residents to minimize interaction, and therefore infection spread between groups. Different levels of cohorting between staff and residents may be required at different stages of the pandemic. Decisions on cohorting must also account for staff availability and skill, and should consider all staff, full-time and part-time. Below is a recommended approach for escalation of cohorting practices through a pandemic.

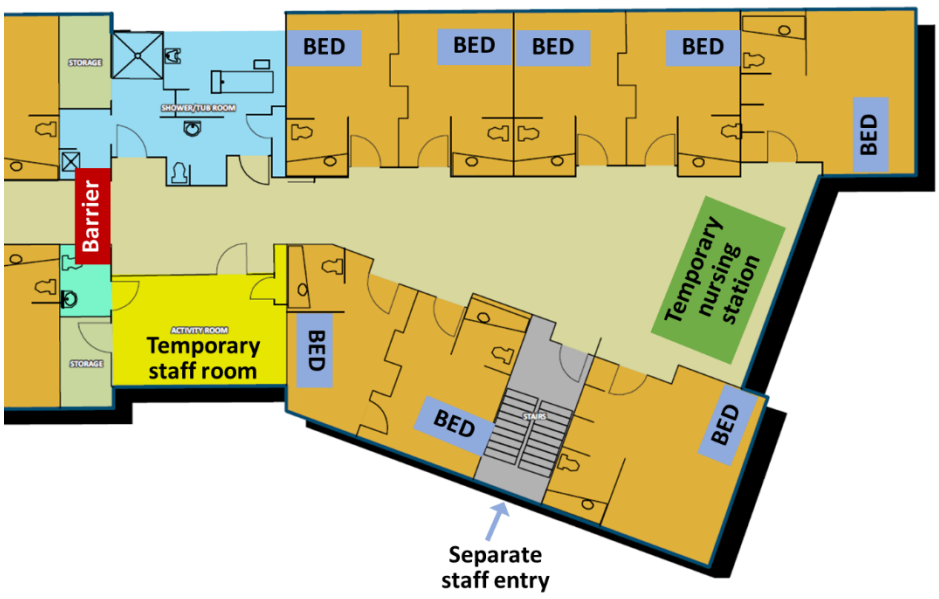
	Resident	Staff
Prevention / Preparedness	• **Shared rooms:** Where possible, find alternate accommodation to enforce physical distancing	• To avoid asymptomatic spread, staff schedules should be modified so all (care, housekeeping, recreation, etc.) **staff only work in one unit / floor,** or common areas • When not possible (e.g. staff shortage), assign staff to **specific residents** as much as possible
Outbreak *(Resident cases)*	• Any suspected or confirmed case must be placed in a **single room**; positive cases should not share rooms with negative/unconfirmed cases • Positive residents should be relocated to **adjacent rooms**, ideally in a **self-contained unit** (dedicated entrance, bathroom, and equipment), e.g., part of unit, entire unit / floor • Other rooms in the home (e.g., common areas) may be considered for cohorting residents	• Staff should be dedicated to **only well or unwell residents / unit**; schedules to be adjusted • If an entire unit is declared in outbreak, staff should avoid caring for negative / unconfirmed residents at the same time as positive residents • Unit should be **self-isolated**, with dedicated staff room, restrooms, entrance, etc. • Cohorting specific staff with positive residents also makes it easier to focus education for managing positive cases to this specific cohort

The below is an example of a self-contained isolation section within a unit for 8 cohorted residents, which can be used to separate positive cases from negative cases within a unit.

In this scenario, the isolation unit has its own nursing station, staff entrance, staff room, and bathroom. Staff are screened prior to entering. Residents in the other portion of the unit would require bedside bathing or use the shower/tub room in the other unit of the floor, depending on what is deemed safest for residents in both units. Thorough disinfection would be required between usage by the two separate units.

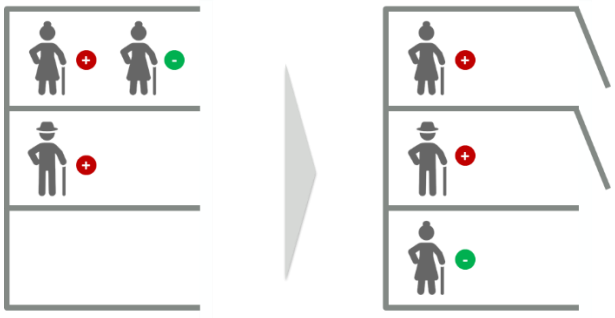
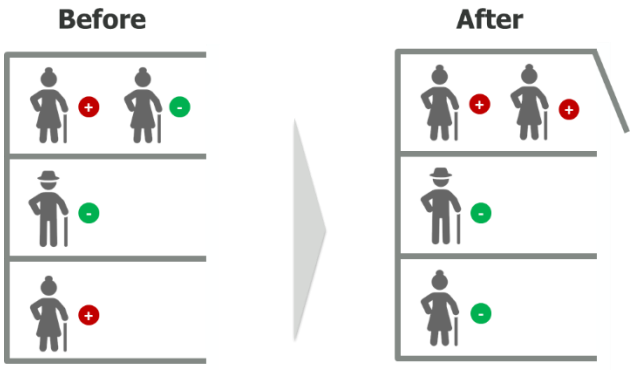
Capacity could be augmented to 10 by having 2 positive residents in semi-private rooms. If using this isolation unit for negative residents, no rooms should be shared.

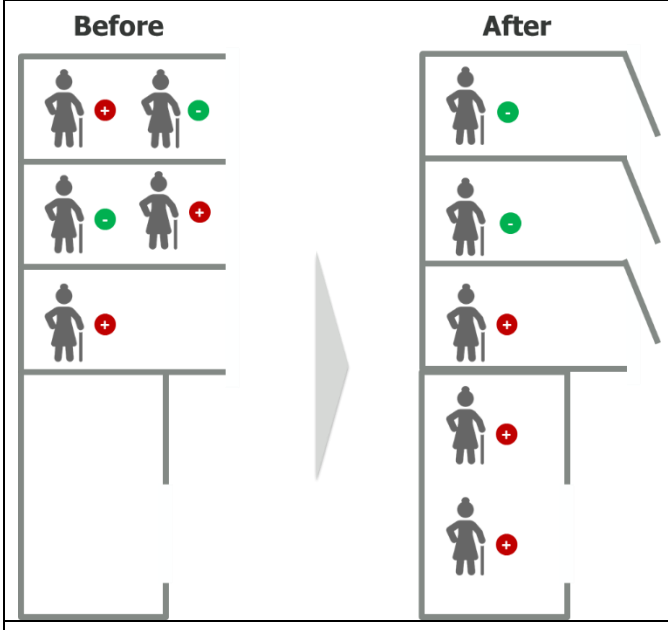
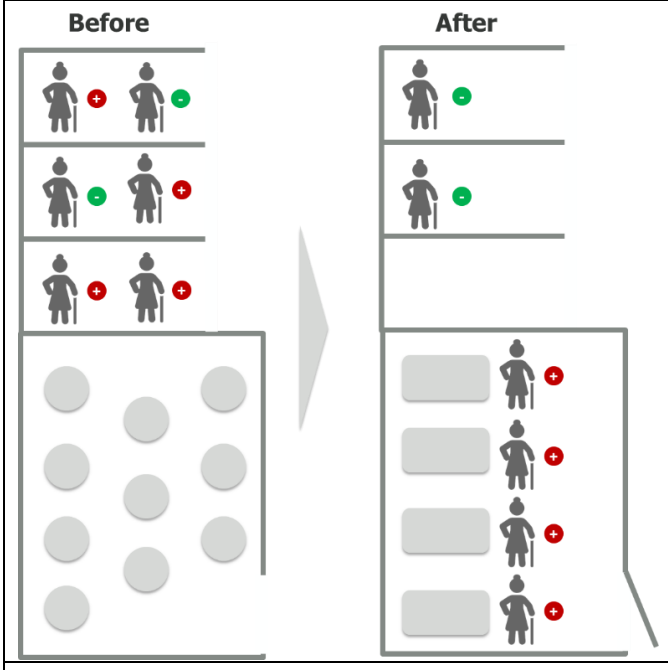
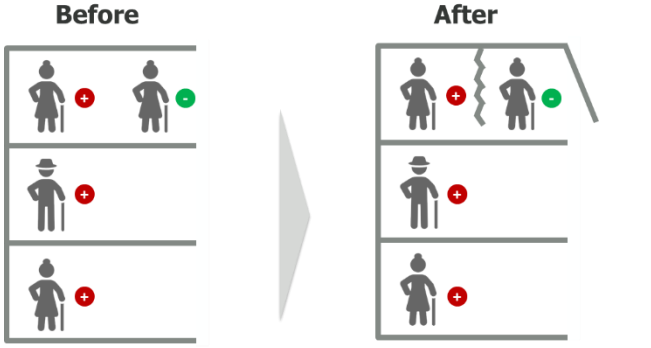
When implementing cohorting measures, it is important to consider the level of risk positive residents pose to other residents. Ideally, all residents would be in a single room. However, where this is not possible, the below shows best practice for cohorting ill and healthy residents.



COHORTING AND ISOLATION OF RESIDENTS

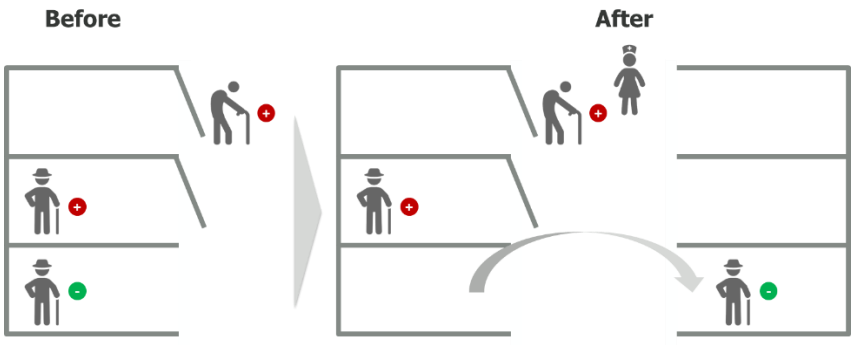
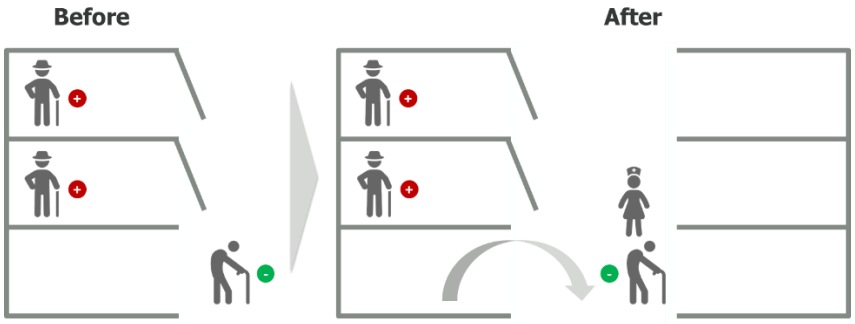
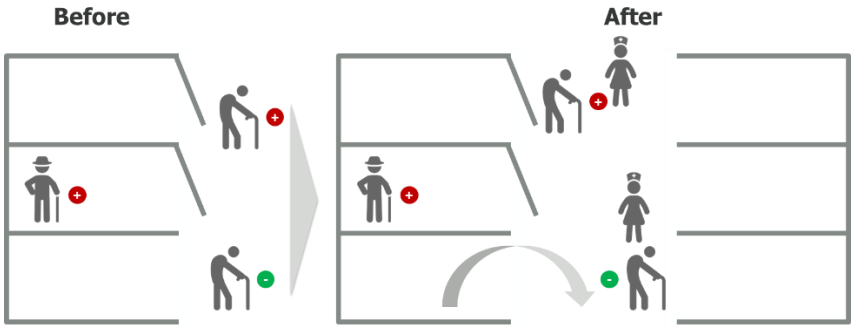
If there is one or several positive cases, it is crucial to implement strict cohorting both for staff and residents (if not in place already) including isolation of positive residents. The overview below outlines possible scenarios. Note that a combination of scenarios may be required.

Cohorting examples	Description
Before / After 	• If a positive and a negative resident are in a shared room, it is highly recommended that each positive resident is isolated in a dedicated room • A room for isolation of a positive resident is ideally in a self-contained unit (dedicated entrance, bathroom, and equipment)
Before / After 	• If it is not possible to provide a separate room to each resident, positive residents can be cohorted together with a physical barrier separating them (e.g. plexiglass or plastic curtain) • Available space can be used to accommodate negative residents

Cohorting examples	Description
	• If there is not enough available space, additional spaces (e.g. recreational room, chapel, dining area, etc.) can be used for cohorting purposes • It is important to consider that use of auxiliary space requires preparation and should comply with building codes, fire safety, etc.
	• One of the biggest common spaces in an LTC home is often a dining hall / room. Especially older buildings have one larger dining room as opposed to each unit / neighbourhood having its own dining space • If an outbreak is in the advanced stages and most residents are moved to a tray service, there is an option to use dining space as a COVID-19 unit cohorting positive residents. • Numerous preparations must be made such as providing beds, mattresses, plastic separating curtains, electric outlets, bell system, etc.
	• In some cases, it is not possible to find any additional space to separate positive and negative residents located in the same room. • Though not recommended, there is a last-resort option to use plastic separators / curtains to separate residents and ensure at least 2-meter space between them • Full PPE change should be in place when moving between residents. • This is not a recommended scenario and should be considered only when none of the other options are available.

COHORTING AND ISOLATION OF RESIDENTS IN A SPECIAL CARE SETTING

Should the outbreak impact unit(s) with residents prone to wandering (e.g. Special Care), additional measures are required for those residents, both positive and negative. Please see below possible scenarios.

Cohorting examples	Description
	• If a positive resident wanders, they pose a risk for both wandering and non-wandering negative residents • A possible course of action is to move negative residents to another unit and surveil the positive wandering resident
	• If a negative resident who wanders is in a unit where there are positive cases, there is a risk for this negative resident • A possible course of action is to move a negative, wandering resident to another unit and surveil them
	• If there is a mix of negative and positive residents who wander in the unit, there is an increased risk for negative residents • A possible course of action is to move negative wandering residents to another unit and surveil both positive and negative wandering residents

COHORTING AND ISOLATION OF STAFF

- **Negative staff, Positive resident:** It is important to remember that there is a significant risk when a negative staff member cares for a positive resident: Contact and Droplet precautions PPE should be used when entering the unit of a positive resident. **Staff that work with positive residents should ideally not work with negative residents**.

- **Positive staff:** If a staff member is positive, they must immediately be sent home for self-quarantine. Tracing of possible contacts to be initiated.

Note that in exceptional cases, positive staff members may be asked to return to work under 14 days of self-isolation. Usually, these staff have shown low to no symptoms and should perform work self-isolation.

- The staff member is deemed essential to operations (e.g. administrator, physician) and the tasks cannot be executed remotely
- Positive staff members should care only for positive residents

This decision should be made jointly with home administration and Public Health. See 5.2.2 WORK SELF-ISOLATION FOR STAFF for more information.

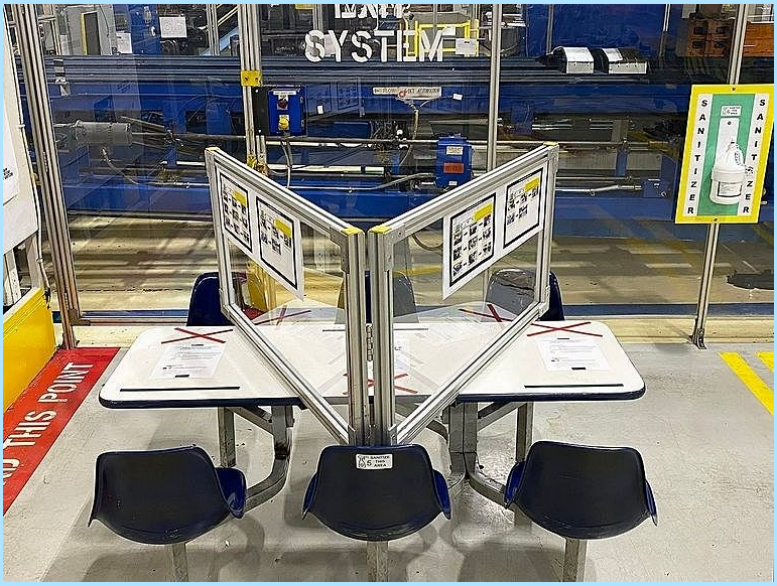
4.5 BUILDING AND PHYSICAL LAYOUT

#	Steps to implement	Done
1	**Limit number of public entrances** to the building. All entrances should be monitored 24/7. • One-single-point of entry: Easier to implement but occasionally poses higher risk if multiple employees show at the door at the same time. • Separate entrances for different purposes (e.g. ill vs. well units): This approach requires more management Note: Ideally, only one entrance is accessible for all staff and visitors, and all others are locked with signage redirecting to the main access. Exceptions can be made to provide access for staff to a self-contained isolation unit to promote separation of infected and non-infected units' staff. These entrances should also be monitored 24/7 and all those entering should be screened.	
2	**Access to the community** is to be limited to staff (employees, volunteers, agency staff) and essential visitors (see 4.12 VISITORS for definition)	
3	A **process should be in place to record all who enter and exit** the home, including essential visitors (full name, contact information, resident visited, in/out time). This can be done by the same person performing entrance screening	
4	Ensure **elevators are disinfected between each use** (buttons, bars, anything touched with Oxivir wipes) and avoid leaning on walls of the elevator. Place disinfecting wipes in or near the elevator. If possible, separate elevator use by purpose, (e.g. "Clean" elevator (e.g. for all non-positive residents, staff, clean goods), "Soiled" elevator (e.g. soiled laundry), Food Elevator (strictly for food and dietary staff to protect the kitchen)).	
5	**Move / remove seating** in common areas to ensure physical distancing	
6	**Reconfigure dining areas** where necessary to ensure physical distancing is maintained for all residents Note: Separate sittings may be required	
7	**Place markers** on the floor and across the home to promote physical distancing (keep 2m apart), especially in high traffic areas: • E.g., Nursing station, Elevator waiting area, Bathrooms, Kitchen, Staff rooms, Entrance, smoking areas, etc. • See example breakroom measures below	
8	**Hand sanitizer** should be placed: • Outside any room where there is a suspected or confirmed case • At the building entrance • At dining room entrances • In care areas	
9	Place the following **items at the entrance** of the building: • Alcohol-based hand rub (ABHR) with 70- 90% alcohol concentration • Tissues • Procedure masks • Proper use signage • No touch waste receptacle	

Example control measures in a breakroom

In order to minimize risk of spreading infection among staff and residents, several control measures can be taken in the home environment, as those included in this example:

- Physical barrier to minimize airborne particle transmission while eating, but also allowing staff to socialize
- Red Xs to mark seats that cannot be used to emphasize physical distancing
- Signage to remind staff of key precautions to take before, during and after breaks
- ABHR at the entrance



4.6 RECEIVING SUPPLIES AND PACKAGES

#	Steps to implement	Done
1	Food and product deliveries should be dropped in an **identified staging area**, ideally outside the facility to avoid having delivery staff entering the facility and enable contactless delivery	
2	**Delivery personnel screening** should be done prior to delivery	
3	**Signage** should be posted at regular reception doors notifying delivery staff to report to the main entrance for screening	
4	Implement clear rules for handling all supplies received. • Supplies should be dropped in a designated area outside the facility • Suppliers should not enter the facility • Staff should not come within 2 meters of suppliers • Supplies should be disinfected • Maintain a log of everything received and who received/handled it (including care packages) to allow for contact tracing should staff or residents become ill soon after (See example)	
5	**Home care packages** can be permitted but should follow supplies disinfection protocols. • Wipe down with disinfectant before bringing into the home • They should NOT include homemade food items (pre-packaged only) • The home may refuse items such as perishables or items that cannot be disinfected • Family/friends should be instructed to wash hands before preparing packages and not send items if they are unwell • It is recommended that items be packaged and delivered in plastic bags to allow for easy disinfection • Items that cannot be disinfected should be held for 72 hours	
6	**Review local outbreaks** regularly and confirm whether facility shares suppliers with facilities in outbreak. If there are shared suppliers, evaluate the risks of receiving the delivery and take appropriate measures, which can include any of the below: • Cancel delivery • Receive in separate staging area from other stock and disinfect thoroughly • Implement longer waiting period • Ensure no staff comes within 2 meters of delivery personnel, equipment or vehicle • Provide PPE for staff handling the delivery	

4.7 RISK FOR STAFF OUTSIDE THE HOME

Staff should take all necessary precautions to avoid bringing diseases into the facility. In the event of a pandemic, additional measures exist to limit staff's exposure.

#	Steps to implement	Done
1	Staff should **inform the facility** if anyone they live with has been exposed to the virus (e.g. worker at other LTCH in an outbreak, hospital staff, etc.) or if they exhibit any symptoms	
2	Staff should **only bring into the facility what is essential** for their work. Best practices recommend not carrying coffee mugs, water bottles, etc. in resident care areas as they can become contaminated. If staff bring lunchboxes, coffee mugs, etc. they should be disinfected when brought in, and lunch boxes stored in a plastic box disinfected between each use. The facility can provide lunch to reduce the amount of food and bags being brought in.	
3	Staff should **apply physical distancing of 2 meters at all times**, including in their personal time and on their commute to work. • Avoid handshakes • Avoid crowded places and non-essential gatherings • Limit contact with people at higher risk • Keep a distance of 2 arm lengths from others	
4	Staff members should **shower** before and after work including hair washing and **wash their work clothes**.	
5	If staff are using **mask headbands or hats**, they should be washed daily	
6	Best practice requires **staff to change clothes** at the facility when arriving and leaving so "outside clothes" are not used inside the home Note: Consider adding lockers to accommodate this practice	

4.8 STAFFING CHANGES

#	Steps to implement	Done
1	The home may **take all necessary steps required to prevent and respond to the pandemic**, including changes to work and shift assignments, cancellation of vacation or leave of absence, hiring additional part-time / temporary / contract staff, using volunteers to perform work. All grievance processes are suspended for the duration of the emergency.	
2	Staff and residents should be cohorted to prevent spread of infections. **Staff cohorting** may include: • Designating staff to work with specific residents and / or units • Designating staff to work with either ill or healthy residents • Changing schedules so cohorts of staff work the same shifts and schedule (e.g. day shift 4 on – 4 off) **Resident cohorting** may include: • Alternative accommodation to maintain 2 meters physical distancing • Resident cohorting of the well and unwell • Utilizing other rooms as appropriate In smaller LTCH where it is not possible to maintain physical distancing of staff or residents from each other, all residents should be managed as if they are potentially infected, and droplet and contact precautions should be used when in an area with a positive case and changed between each resident.	
3	**Breaks and lunches** need to be staggered to help ensure staff are physical distancing. Markers can be used in smoking areas; seating too close together can be removed in break areas.	

4.9 JOINT HEALTH AND SAFETY

Important to know

- For physical health and wellness related concerns, staff can contact a healthcare professional by contacting **Telehealth Ontario at 1-866-797-0000**
- If staff have concerns about their health and safety that the employer is not addressing, they can file a complaint with the **Health and Safety Contact Centre at 1-877-202-0008**
- If a staff member **suspects they may be ill**, they should immediately isolate and not go to work until they are recovered or have received a negative test result; the employer will confirm when the employee can return to work.
- If a team member believes they have **contracted COVID-19 at work**, in accordance with the Occupational Health and Safety Act, an employer must report to WSIB within 72 hours of being notified by the employee
- For more information on **COVID-19 and workplace health and safety**, see https://www.ontario.ca/page/covid-19-coronavirus-and-workplace-health-and-safety

The best way for **staff to protect themselves, residents, and coworkers** is by adhering to infection prevention measures outlined in this document and standard policies. Staff can find specific health and safety guidance from Public Services Health and Safety Association (PHSA) using the following links (all resources can be found here: https://www.pshsa.ca/covid-19):

- Long-term Care guidance
- Administration in Healthcare
- Foodservice Workers in Healthcare
- Housekeeping and Laundry in Healthcare
- Nurse in Healthcare
- Personal Support Worker and Care provider
- Recreational Worker in Healthcare
- Social Worker

Frontline workers need to be mindful of their own health and wellness, including pandemic related stress and anxiety, compassion fatigue, and exhaustion. Several resources are available for workers to get **help and support to help with mental health**. Note that these resources are available both for pandemic related issues as well as general mental health.

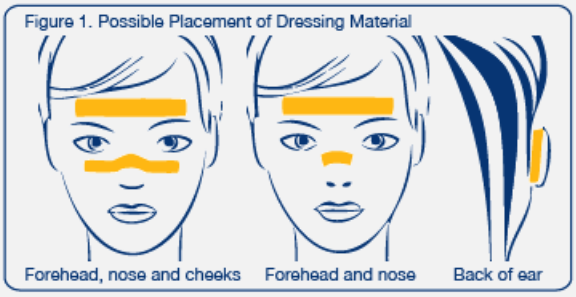
Resources	Notes	Contact
EAP	The City's Employee and Family Assistance Plan **Homewood Health™**	800.663.1142 www.homewoodhealth.com
ConnexOntario - Ontario Mental Health helpline	24/7 Chat also available: https://www.connexontario.ca/	1-866-531- 2600
Canadian Mental Health Association crisis help line	24/7 Also available via text: 45645	1- 833-456-4566
CAMH Mental Health supports for Healthcare Workers negatively impacted by COVID-19 self referral form	CAMH is providing access to mental health and addiction supports for health care workers in need of support who might be negatively impacted by COVID-19. These services include access to resources, Cognitive Behavioural Therapies (CBT/Psychotherapy) as well as Psychiatric Services.	https://redcapsurveys.camh.ca/redcap/surveys/?s=JK4XK83AYC
BounceBack	Free guided self-help program that's effective in helping people who are experiencing mild-to-moderate anxiety or depression, or may be feeling low, stressed, worried, irritable or angry.	https://bouncebackontario.ca/adults-19/
Wellness Together Canada	Wellness Together Canada provides tools and resources to help Canadians. These include modules for addressing low mood, worry, substance use, social isolation and relationship issues.	https://ca.portal.gs/
AbilitiCBT	AbilitiCBT is an internet-based cognitive behavioral therapy (iCBT) program that you can access from any device, any time.	https://ontario.abilitiicbt.com/home
BEACON	Online CBT. BEACON includes specific support for frontline health workers.	https://info.mindbeacon.com/btn542

Additional Information and Resources

- CAMH Resources for Healthcare workers: Mental Health and COVID-19
- Ontario Government Support resources for health care workers (includes self-led support, peer support and clinician resources
- CMHA Mental health tips amid COVID-19 concerns
- Local CMHA branch services
- WHO Poster: Coping with stress during the COVID-19 outbreak

4.9.1 PPE SKIN DAMAGE

Continuous extended use of PPE may cause skin reactions such as itching, rashes, contact dermatitis, etc. Factors that may contribute to skin irritation include: length of wear time, pressure, friction, sweating, the use of cosmetics and skin products. Below are a few strategies to prevent and manage skin damage:

	Prevention Measure
Damage from surgical mask	• Alternate mask placement slightly daily to avoid friction over the same area • If ears are irritated, use approved items to pull away ties from the ears • Use dressing material on areas with frequent pressure (do not use with N95)  • Moisturize face before and after work with a water-based moisturizer, and frequently at home • Do not use barrier creams or oil-based moisturizers (e.g. petroleum jelly) as those increase contamination
Damage from eye protection	• Avoid over tightening goggles • Wash straps with plain soap and water and allow to dry to prevent irritation from sweat on straps
Damage from gloves	• Avoid wearing gloves for extended periods of time if not required by PPE measures in place
Hand Hygiene	• Use warm water to minimize damage • At home use gentle / plain soaps and cleaning products to minimize irritants • Moisturize hands before and after work with a water-based moisturizer, and frequently at home • If moisturizing hands at work, use a small amount to avoid leaving an excessive layer on skin • Do not use barrier creams or oil-based moisturizers (e.g. petroleum jelly) as those increase contamination – these products can be used to moisturize at home

4.10 WORK FROM HOME

WHO SHOULD WORK FROM HOME?

The home should make every effort to facilitate work from home where possible to limit the number of people on site who could potentially bring in the disease. However, this cannot come at the cost of quality of care or staff health and wellness. The below outlines general recommendations as to who should and shouldn't work from home.

Role	Recommendation
Admin / Management	• Some staff in administrative functions may be able to work from home; decisions should be evaluated on a case-by-case basis by the Administrator / City officials
Nursing / Care	• Staff providing direct resident care usually cannot work from home
Medical / Physician	• Physicians / medical officers and specialists may not be cohorted and can pose a great risk for transmitting infection given the number of residents they typically see • Remote consultations should be facilitated as much as possible using tools such as On.Call Health • Nursing / care staff in each cohort will need to be available to facilitate video conferencing (e.g. hold tablet from room to room) • Physicians may still come on site where needed but should limit contact to a minimal number of residents and use PPE • It is recommended to weigh the risk of having physicians consult remotely (e.g. risk level of the population, impact on care, etc.) against the risk of transmission if onsite
Recreation	• Recreation staff should be cohorted and facilitate individual / in-room recreation programs • If less recreation staff is required on site, consider whether additional staff can be redeployed (e.g. to environmental services)
Environmental	• Staff performing environmental duties (cleaning and disinfection, laundry, waste management) usually cannot work from home
Dining	• Staff performing dining duties (cleaning and disinfection, laundry, waste management) usually cannot work from home • Dieticians can work from home
Pharmacy	• Staff performing pharmacy duties usually can work from home and should follow pharmacy specific policies

REQUIREMENTS FOR STAFF WORKING FROM HOME

Tools and Equipment

- Computer (policy should specify whether personal devices are allowed, or the home will provide devices)
- Internet access
- VPN connection
- Conferencing tools / software (e.g. Microsoft Teams)
- Access to key programs (e.g. Office, PCC, HR system, etc.)
- Access to key information (e.g. schedules)
- Remote access / remote desktop if required (e.g. for local intranet)
- Re-route phone calls from office phone (Requires ITT Services support)

Policies and Processes

- Security policies, especially for protecting employee and resident data
- Helpdesk / Contact for any issues encountered
- Clear guidelines on who to reach and for what, including method of communication (e.g. text for emergencies)

4.11 RESIDENT-SPECIFIC PROCEDURES

4.11.1 ESSENTIAL RESIDENT CARE

#	Steps to implement	Done
1	Every health care worker must perform a **point-of-care risk assessment (PCRA)** before any resident interaction (See 4.3.2 POINT-OF-CARE RISK ASSESSMENT (PCRA))	
2	Ensure residents' **care goals / advanced directives** are known and up to date (e.g. DNR, funeral arrangements, etc.)	
3	Ensure **resident care is maintained** under all circumstances, including: • Personal care • Bathing can be done at the bedside, at a minimum once per week • Care of fingernails and feet may be rescheduled as required • Medication administration • Ongoing assessment of care needs • Routine catheter care • Skin and wound management and colostomy care • Assistance with eating as required; G-tube feeding and maintenance • Oxygen therapy as required • Residents with mobility concerns and/or at risk for skin breakdown will be repositioned • Follow outbreak management policies • Advanced care planning will be followed and updated as required • Non-urgent medical appointments can be rescheduled	
4	Infection prevention calls for **increase in care** in the following areas: • Handwashing • Bathing • Laundry	

4.11.2 ISOLATION AND MENTAL HEALTH

Important to know

A pandemic situation poses enormous psychological pressure on residents as they might become isolated from their family, loved ones, and from each other. These are not normal times, so please consider the following:

- Residents may have increased feelings of anxiety, worry and frustration in the absence of visits from family and friends
- Changes to routines in activities and mealtimes may cause uncertainty and stress

#	Steps to implement	Done
1	**Prevent distress due to isolation** by calling residents to chat, checking in with residents who know them, asking residents about a topic they like.	
2	Use information you know about the resident to **start conversations** • Use get to know me sheets to collect and share information on residents (See template). These tools, while created for dementia care, can be used for all residents to allow staff to start conversations with residents, or to update families on their loved ones.	
3	Use **technology** to mitigate the effects of isolation, where available, e.g. • E.g. Video calls with family and friends, virtual games, virtual outings	
4	Encourage residents to do **in room exercise** where possible to promote physical health during isolation	
5	Find a bit of time for a **daily small gesture** • E.g. leave printed quote in room, daily greeting / prayer over PA, Resident spa (bubbles and battery-operated candles in tub), short video from family, bubbles in the garden, flower on plate, staff crazy hair day, joke of the day	
6	Use **ideas from recreation department** on ways to brighten residents' day safely, e.g. • In-room activities: E.g. crosswords, knitting, puzzles, painting, movies, TV, music, mini-activity kits, devotional reading / prayer for spiritual residents, painting rocks to leave around the community • Hallway activities: E.g. bingo, adapted board games, sing-a-longs, live music by team member, hallway meditation, exercises)	

4.11.3 INTERACTION WITH FAMILIES

Important to know

It is important to remember that a pandemic situation puts a lot of pressure on family and loved ones who are worried about their family members in the home:

- It is important to keep them informed about the status of their loved ones and the home as a whole
- In the absence of in-person communication, explore other ways to keep families connected with their loved ones as both sides can benefit from it –ideas are included in the list below

#	Steps to implement	Done
1	**Home care packages** can be permitted but should follow supplies disinfection protocols. • They should NOT include homemade food items (pre-packaged only) • The home may refuse items such as perishables • Family/friends should be instructed to wash hands before preparing packages and not send items if they are unwell • Items should be placed in plastic bags to allow for easy disinfection	
2	Families should be encouraged to keep in touch with residents through **phone / video calls** facilitated by staff	

#	Steps to implement	Done
	• Provide a method to schedule such calls through recreation staff or designate, online form, etc. • Help residents with technology as needed	
3	Encourage families to provide **tablets or other means of individual entertainment** to their family members	
4	Where appropriate for the resident, families should be encouraged to do **window visits** Facilitate scheduling of these visit via email or phone to avoid overcrowding and potentially putting families in danger. Note: Best practice is to supervise residents for window visits, as some may attempt to open windows to touch family	
	It may be feasible to facilitate family visits outdoors during summer. Note however that all distancing measures apply, and facilities should ensure no resident comes in contact with a family member if allowing these visits. A few best practices include: • Communicate with families, and set expectations regarding frequency of visits, format, etc. • Schedule visits ahead of time so only a limited amount of families are present at once • Provide clear guidelines to the family regarding distancing • Explain distancing measures to the resident • Prepare the space outdoors to ensure a comfortable visit while distancing (e.g. benches 2+ meters apart, barrier in between if risk of resident not respecting distancing, etc.) • Ensure a staff member is available to accompany the resident throughout the visit	
5	Encourage families to **send photos** to resident regularly	
6	If possible, **capture photo(s) / video(s)** of a resident to share with a family member Note: Prior consent from resident and family may be required, and staff should not use their personal device to record images of residents	
7	Update families on any **changes in visitor policies** as they are eager to see their loved ones in person again • Depending on Public Health guidance, there might be some precautions put in place (e.g. PPE, distancing, etc.) • Ensure adequate space is allocated for visits, either a dedicated room disinfected between each visit or an outside space • Ensure visits are scheduled to ensure infection prevention practices can be maintained	
8	Gather **family contact information** as well as contact method preference (for Cliniconex)	

4.11.4 SPECIAL CARE UNIT

In a pandemic, special measures need to be taken to protect residents living with dementia, as it may be more challenging to enforce physical distancing, hand hygiene and isolation protocols. Special care needs to be placed on those individuals who tend to wander, especially as isolation may trigger boredom. In order to ensure the safety of both those with dementia and those living/working close to them, the main objective of this section is:

- To prevent those individuals from entering a room where someone is in isolation to protect themselves
- To ensure those individuals remain in isolation if they present symptoms to protect others

#	Steps to implement	Done
1	Depending on residents' capabilities, **explain the pandemic situation** to them and measures in place. DementiAbility has an LTC specific resource that can be used for these conversations.	
2	Ensure **staff is appropriately trained** in dealing with residents with dementia using nonrestrictive measures (e.g. Gentle Persuasive Approaches, P.I.E.C.E.S. Approach)	
3	**Residents who wander should be clearly identified** and all staff in the unit should be made aware. A thorough review of previously completed behavioral assessment to **identify triggers** should be performed for each resident, noting any recent changes in behavior (e.g. due to isolation). Staff should **keep track of underlying causes** of behavior and deterrents that work and implement a log that can be shared across shifts.	
4	Should a wandering resident exhibit any infection symptoms, **consider implementing one-on-one staffing** until they can be declared virus-free. If this is not feasible, ensure regular visual checks on the individual are performed.	
5	Wandering positive residents pose a risk to staff as well, as they may not be able to don PPE in a timely manner. Staff should attempt to have the resident return to their room through **verbal redirection from a safe distance**. If any specific cues have been effective with a resident, staff should capture them and share with other staff.	
6	Consider cohorting isolation rooms within a special care unit with **positive residents who tend to wander into a self-contained unit** to avoid having wandering individuals mix.	
7	Provide clear **markings** for that individual to identify / find their room.	
8	If the resident wanders frequently, the following **enhanced hygiene** measures should be in place: • attempt to mask them when outside their room / during daytime • wash their hands frequently (could have them play with soapy water / washing dishes as an activity) • bathe / shower frequently	
9	Use **visual cues** at eye level to deter the individual from entering areas of risk • Velcro/magnet wander strips • Red stop signs • Written signage (e.g. Do not enter) • Colored tape to mark doors / floor in front of isolation rooms	
10	Consider **other methods of deterring / preventing entry** to isolation room: • Camouflaging doors / door handles for isolation rooms using curtains, posters, etc. • Wander / door alarms	
11	Promote **exercise / movement** provided safe distance can be kept (dependent on health condition) • Doorway / in -room workouts • Walk in safe area If currently under isolation, the resident should be in full PPE when going outside the room.	
12	Ensure **bathroom needs** are met • Visual cues leading to bathroom, signage on door • Cues / assistance to go to bathroom frequently	
13	Make the individual's **room appealing**: • Play their favorite music or TV show in their room	

#	Steps to implement	Done
	• Pictures of family • Stick items on room window (e.g. decals) • Plants in room (can be artificial) • Set up activities in the room (e.g. towels to fold, playing cards) • Place floor markers in their room to provide a walking path	
14	**Minimize noise / stimulus outside** rooms	
15	**Increase one on one programs**, including sensory stimulation activities	
16	Consider **family visit** for wandering resident (ensure screening is done)	
17	Decisions on physical, chemical or environmental **restraints** should be made with ethicist, as per normal procedures. The use of physical restraints in the context this pandemic is generally not recommended, as they may exacerbate behavioural issues in combination with isolation and lack of contact with family.	

For additional information, please see RGP-BSO Guidance to support clients who wander and require isolation or the Alzheimer's association tips for dementia caregivers in LTC settings.

4.11.5 SEMI-PRIVATE ACCOMMODATION

#	Steps to implement	Done
1	Consider **alternative accommodation** to support resident physical separation. This can include: • Using available single rooms • Using other rooms (e.g. common areas with call bells) • Installing physical barriers in the room (e.g. plastic shower curtain) Positive residents may be roomed together in a room if no alternatives exist, allowing for socialization. Avoid sharing rooms for negative residents as they may be asymptomatic. Note: Consider wandering history of each resident when making these decisions	
2	**Separate PPE carts** should be in place for each resident in the room	
3	Staff to implement **enhanced universal precautions**: donning and doffing complete PPE in-between residents, even when they are in semi-private room.	
4	Staff should **separate all personal items of each resident** for the duration of this pandemic (may require purchasing shelves or plastic baskets to ensure separation of personal hygiene products)	
5	**Sanitize bathroom** and touch points pre-, and post-care with 1-min-kill-time e.g. Oxivir TB. This is required to be done each time the bathroom is used	
6	Best practice for residents in semi-private rooms, when possible, is to have them wear a **surgical mask**	
7	Residents with **CPAP** should ideally be moved to a single room. Once on Contact/Droplet precautions they must be in a single room.	

4.11.6 RESIDENT APPOINTMENTS, VACATIONS AND HOSPITAL TRANSFERS

#	Steps to implement	Done
1	Residents are **permitted to leave the home** for short-term absences, vacation, appointments (e.g. visit family or friends) and for prescribed medical reasons (e.g. dialysis, transfusions, etc.)	
2	If a resident leaves the home for an **outpatient visit or hospital transfer**, the home must mask the resident if they tolerate it. If not, those handling transfer should wear contact and droplet precautions if the resident is suspected or positive	
3	When a resident returns, they should: • Screen resident before entry to the facility • Provide them with a mask • Put in droplet and contact precautions • Request tray service • Screen for 48-72 hours post-arrival (or prescribed window before testing new infection) • PCR on day 5 or after	
4	If a resident is referred to a hospital, the home should coordinate with the hospital, local PHU, paramedic services and the resident to maintain appropriate isolation precautions during travel	
5	Notify family if resident is to be transferred to hospital	

4.11.7 END OF LIFE PROCEDURES

#	Steps to implement	Done
1	Coordinate **family visit** provided they can follow safety procedures for essential visitors: • Screening prior to entry • Up to 4 visitors at a time • Follow PPE protocols • Maintain physical distancing from resident	
2	Though it should be discouraged, if the family member had **close contact** with the resident, consider isolating the resident and monitor for symptoms	
3	• If family cannot visit (e.g. at risk individual, failed screening, many people, etc.), schedule a **video call** with the resident	

4.11.8 POST-MORTEM CARE

Important to know

The Ontario Chief Coroner released guidelines for an Expedited Death Response (EDR) process April 14th, 2020, applicable to all LTC homes.

- This process supersedes any existing processes for managing resident deaths, and **applies to all resident deaths**, whether or not the home is in outbreak.
- The below outlines key steps; a more detailed directive can be found on the Bereavement Authority of Ontario's website
- A **clinician no longer needs to enter** the facility – RN or RPN can pronounce death and the OCC will submit MCOD electronically
- Contact for Ontario Chief Coroner (OCC) team: 1 (833) 915-0868 (7 days / week 6am-8pm)
- A summary sheet outlining the process for LTC can be found in templates

#	Steps to implement	Done
1	Assign staff to form **Managing Residents Death Team (MRDT).** This can be one individual (usually DOC), or several team members depending on the size of the home. Important considerations include: • Ability to manage the sensitive nature of conversations with grieving families (i.e., choosing a funeral home) • Professionals who have likely interacted with the families previously • Ability to facilitate completion and submission of documents to OCC Team • Note: The **MRDT will manage all resident deaths** in the home during the pandemic, or until new instructions are provided	
2	**Funeral arrangements and Advanced Care Plans** should be reviewed ahead of time to enable quick response	
3	MRDT to **establish a release location outside** the home where funeral service providers to exchange stretcher and process for contacting MDRT upon arrival at the home	
4	Continue **Droplet/Contact precautions** if they were in place prior to passing if entering the room (handle as active case)	
5	Deceased should remain in their room until funeral services arrive – if shared accommodation, other residents should be moved out temporarily	
6	MRDT to **contact the family** and confirm funeral home as soon as possible (request a body bag if none are available in the facility) – family should contact funeral home	
7	MRDT to **contact funeral home** and share: • Family contact information, and inform that family will call • Name of the deceased resident • LTC home name and site • Location of release • Contact process at the time of arrival • COVID-19 status of deceased Note: Funeral home is not expected to attend LTC home after 8pm unless other exceptional circumstances (no designated morgue space may be deemed exceptional circumstances)	
8	Funeral service providers **will not enter the facility** at any point	

#	Steps to implement	Done
	• Funeral home will provide a stretcher at the door (and body bag if requested) • Label body bag with resident information (full name, date of birth) and label "COVID-19" on body bag if positive or suspected – ensure ink does not come off in disinfecting process • MRDT will place resident in body bag and onto stretcher • Ensure identification arm band is present and matches label outside body bag • Prior to moving out of the room, wipe down the outside of the body bag completely with a disinfectant solution • Stretcher will be transferred to funeral service provider outside • Wipe down again with disinfectant solution at point of release • Staff who have handled the body should follow all hygiene procedures	
9	**PPE for handling deceased** residents (regardless of COVID-19 status) include: • Gloves (remove once transferred to stretcher and perform hand hygiene) • Mask • If there is a risk of bodily fluids splashing, also use gown and face protection	
10	Throughout post-mortem activities, **any activities which can increase the risk of infection should not take place**. This includes: • Placing blankets over the body bag • Washing the body, removing clothing or any other activities that can increase the chance of splashing of bodily fluids • Family touching the body or following deceased to release • Suspension of honour guards and other ceremonies	
11	Complete **MRDR package as soon as possible** • Use template provided (not online portal) for Institutional Patient Death Record (IPDR) • Send to OCC team (occteam@ontario.ca / Fax: 1 (888) 247-1845)	
12	Revise practices in place to **honor residents** that pass and adapt to new processes to allow residents and staff to say final goodbyes. Ensure activities do not pose risk of infection, nor interfere with the need to move quickly. Options include: • Prepare posters ahead of time that residents or team members can hold to their windows as the vehicle departs the facility • Give battery operated candles residents can light from their rooms • Make an announcement to take a moment to remember the resident	
13	**Swab for testing** if not swabbed previously and resident was suspected / symptomatic	
14	Follow plans for **managing increased need for post-mortem care** and disposition of deceased residents if applicable (directives from PHO or local funeral homes)	
15	Ensure appropriate **internal reporting and communication** takes place	
16	If resident was positive or suspected case, assume **personal belongings may be contaminated**. Coordinate with family regarding transfer or disposal of possessions.	
17	Follow standard **post-mortem cleaning procedures** and cleaning and disinfection procedures for COVID-19, including PPE requirements.	

4.12 VISITORS

#	Steps to implement	Done
1	Only **essential visitors** should be allowed to enter, defined as: • performing essential support services (e.g., food delivery, phlebotomy, maintenance, family or volunteers providing care services and other health care services required to maintain good health); OR • visiting a very ill or palliative resident; these visitors must visit only the one resident and no other resident	
2	Visitors must be screened at entry (apart from Emergency responders). • If the essential visitor fails screening, refuses to answer the questions, or shows symptoms of COVID-19, they will not be allowed to enter the home. • The screener should inform them to go home and self-isolate and contact local public health unit or telehealth for further instruction. • If any visitor becomes upset or has further questions, staff should contact a manager or designate to handle the situation. • Need to be rapid antigen tested for COVID-19	
3	Essential visitors must: • only visit the resident they are intending to visit and no other • wear a mask at all times • practice physical distancing • wear appropriate PPE if visiting a resident suspected or infected with COVID-19* *Note: Best practice indicates to have all visitors wear PPE when entering the home so as to minimize risk of infection, if possible	
4	Staff must support the essential visitor in appropriate use of PPE: • Demonstration of putting on and taking off PPE safely, as needed • Hand hygiene	
5	If possible, consider dedicating one room isolated in the community that is set up for visits and disinfected after each visit.	
6	Discontinue all non-essential activities (e.g. pet visitation programs)	
7	Facilitate other methods of keeping in touch with residents, including families and specialists, through supporting residents with video calls and phone calls	

4.13 EMERGENCY SERVICES

#	Steps to implement	Done
1	EMS, Police, Fire Services **do not need to be screened** prior to entering	
2	When contacting Emergency services, **inform them if the resident to be cared for is suspected / positive or if the home is in outbreak**.	
3	Maintain **physical distancing from Emergency responders**; assist with distancing other residents from Emergency responders	
4	**Inform the family** of the emergency	
5	**Fax documentation** to hospital prior to sending out resident (hospitals not accepting papers from facility)	

4.14 MEDIA AND MISINFORMATION

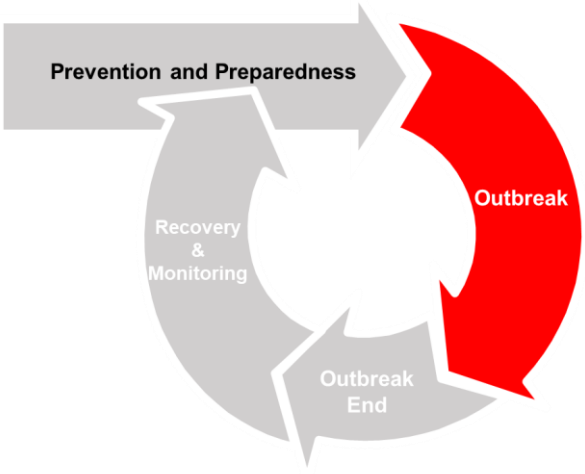
It is critical that messaging is consistent during uncertain times, and so the home requires that no employees communicate with the press. All requests should be redirected to the Administrator or designate.

All healthcare staff should be wary of misinformation in rapidly evolving situations of pandemic. Staff should always refer to the most up-to-date information from official sources such as the Ministry of Health and Public Health Ontario.

In addition, some institutions have reported receiving phone calls from people claiming to be Public Health or Ministry officials. If a call seems suspect, especially if specific team member or resident information is requested, staff should:

- Not share any information (e.g. “This is not my area, but I’d be happy to get the appropriate person to call you back.”)
- Get the individual’s name and contact details
- Mention the appropriate person will call them back
- Verify the contact with authorities to confirm validity

5 OUTBREAK RESPONSE



This section outlines the best practices and guidelines that all staff should be familiar with in order to deal with a suspected or active outbreak

It is important to note that outbreak measures will stay in place as long as the home is in an outbreak stage. Measures from the Prevention and Preparedness section should remain in place unless otherwise indicated in this section.

This chapter is intended to be shared with the entire long-term care home team to ensure that there is a broad awareness of all measures related to an Outbreak.

5.1 OUTBREAK MANAGEMENT TEAM

Important to know

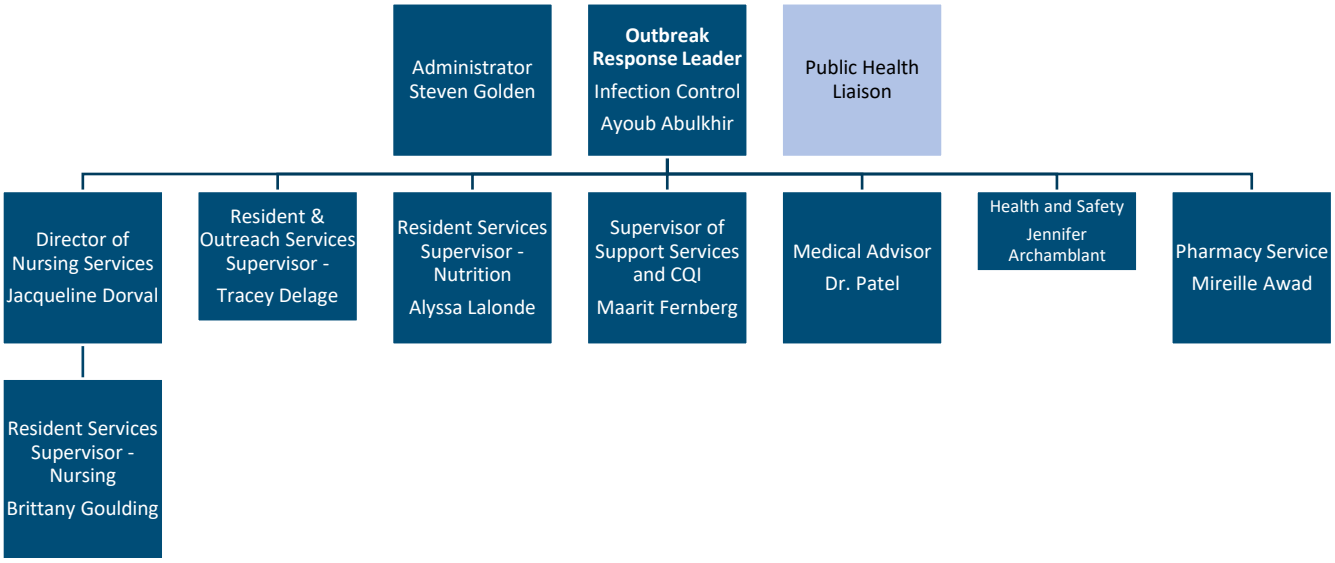
The Outbreak Management Team (OMT) is **responsible for**:

- Identifying, and providing direction when an outbreak occurs
- Outlining an action response to the infection and outbreak
- Providing analysis that focuses on successes or areas of improvement
- Reporting to ICP or designate in the home and all authorities

The OMT should **meet within 24 hours** of notifying the Public Health Department/Ministry of Health or as instructed by authorities; Administrator or designate to activate team

- The team will **meet daily** during an outbreak; on weekends or holidays, registered staff should be designated to monitor the outbreak status
- OMT should include **representatives from all departments** to ensure ICP directives are respected
- Ensure all team members have readily accessible and up to date **list of OMT members and contact** details
- A **backup for each role** should be identified

OMT STRUCTURE



OMT ROLES and RESPONSIBILITIES

Owner	Responsibilities
Outbreak Response Leader	• Lead contact for public health and government agencies • Chair daily OMT meetings to discuss current state and plan for day • Communicate status of outbreak + update on COVID-19 test results • Communicate to all internal staff, residents, families, and public agencies • Inform the Joint Health and Safety Committee • Primary point of contact for the Lab • Keep accurate records on all residents and staff, including all tests • Notify CAO, Ministry of Health and Long-Term Care and Ministry of Labour
Administrator	• Serve as a point of escalation for outbreak task execution challenges • Secondary contact for public health liaison • Lead communicator/point of contact for staff, residents, and families • Prepare and share daily status report on outbreak status • Keep track and order as necessary PPE supplies • Only authorized point of contact for the media (or designate)
Medical Advisor	• Consult and assist OMT as needed • Support and coordinate medical protocols as requested • Liaise between the home and the medical community

Owner	Responsibilities
Pharmacy Service	• Support OMT as needed • Providing pharmaceuticals and anti-infective agents • Forecasting anti-infective agent amounts required
DON	• Record minutes of all interdepartmental meetings • Assist in gathering case statistics • Assist in developing the daily outbreak report • All other admin duties as directed
Resident Services Supervisor Nutrition	• Maintain and plan food quantities • Practice safe food storage and handling (adjust as needed for outbreak) • Follow public health directives • Use isolation trays if needed • Use colour coded bins to identify those used for isolated residents • Ensure all staff are following hygiene protocols, e.g., use of gloves • Keep dining staff outside of isolated rooms
Resident Services Supervisor Recreation	• Cancel activities that place residents at risk, e.g., group activities • Consider safer play alternatives • Generate morale boosters • Promote positivity through messaging and activities • Assist Nutritional Supervisor as needed
Resident Services Supervisor Nursing	• Report on residents' condition • Supervise isolation procedures • Ensure adequate PPE supplies are available (liaise with Administrator) • Lean on extra resources as needed and train on activities required • Ensure isolation area is clear for all staff and residents + restrict access • Liaise with Site Administrator for updates to resident families • Request and monitor unique food requirements
Supervisor of Support Services and CQI	• Direct housekeeping for special cleaning requirements • Ensure adequate cleaning supplies • Teach proper cleaning procedures, per infection control nurse • Ensure isolation rooms are cleaned last • Adjust cleaning schedule routine and timelines as needed
OMT collective responsibilities	• Decide on resident surveillance plan • Decide when to restrict visitor access to home • Develop plans to cohort positive residents • Supervisory requirements for isolation areas • Planning and scheduling of staff • Decide when to declare outbreak is over (in discussion with local PHU)
Public Health Unit Liaison	• Direct and advise OMT • Control outbreak • Communicate with laboratory

OMT DOCUMENTATION

Document	Information to include
Outbreak Log Procedure	• Date and time an outbreak was suspected • Name of person notified • Date and time of decision to declare outbreak • Date and time messages were left (for staff, residents, families) • Date and time statistics were given to Public Health • Dates specimens were picked up and taken to lab
Daily report content	• # of positive cases • # of negative cases • # of deaths • # of resolved cases • # of potential cases pending test results • Results breakdown between resident and employees • Change in status for active outbreak measures being taken • Reinforcement of key outbreak management messages • Positive thought of the day

5.2 SUSPECTED CASE

Once at least **one resident or staff has presented with symptoms** compatible with COVID-19, the long-term care home should **immediately trigger an outbreak assessment** by the local PHU.

#	Steps to implement	Done
1	Any **staff / volunteer / supplier who fails** a screening should: • Not be allowed to enter the facility and asked to isolate at home • Inform their manager / supervisor • Contact Telehealth or local Public Health as instructed • If symptomatic, be directed to get COVID-19 testing at an Assessment Centre (Cornwall Assessment Centre - call 613-935-7762) • Remain at home for 10 days	
2	Upon being notified by the manager Human Resources will **follow up with any staff who has failed a screening**	
3	If a **resident fails** a screening: • **Isolate** immediately (place in single room if currently in shared accommodation) • Put in droplet and contact precautions (See Droplet and Contact Precautions Fact Sheet)* • **Signage** and **PPE** should be placed outside the room • Practice **physical distancing** where possible • Notify **Charge Nurse, DOC or Administrator** (RN or DOC to notify IPC Officer who will notify Public Health) • Notify **housekeeping** staff to disinfect area in proximity of resident • **Test** the resident immediately, and any additional high-risk individuals (e.g. shared room) • Add to **line-listing** • Contact **family** • Request **tray** service • Consider giving a **mask** to resident for time of care and close physical interactions • Consider **visual** (e.g. identifying bracelet/pin/lanyard) to be put on resident for rapid identification of status (in event of wandering or evacuation, or to keep track of cohorts)	
4	Appropriate **supervisors should be notified** if any resident or employee / visitor that has had contact with residents fails a screening or tests positive: • DOC or designate to be notified by screener immediately • DOC should report to Administrator and IPAC officer • Administrator should report to homeowner / head office / municipality • IPAC officer or designate should contact Public Health; if IPAC officer is unavailable, the Charge nurse should report to Public Health • Authorities will provide instructions for testing	
5	Residents who have been **in close contact without source control with a staff who failed a screening** should be isolated as a precaution measure	
6	**Dedicated equipment** (e.g. thermometer, blood pressure cuff, lifts, etc.) should be used in a room where there is a suspected or confirmed case. If this is not possible, all equipment being shared should be cleaned and disinfected before reuse.	
7	Prepare implementation of resident and staff cohorting practices to limit the spread.	

#	Steps to implement	Done
	Staff cohorting may include: • Designating staff to work with specific residents and / or units • Designating staff to work with either ill or healthy residents • Changing schedules so cohorts of staff work the same shifts and schedule (e.g. day shift 4 on – 4 off) **Resident cohorting** may include: • Alternative accommodation to maintain 2 meters physical distancing • Resident cohorting of the well and unwell • Utilizing other rooms as appropriate	
8	Maintain **line listing** for all suspected cases (staff and residents) See sample line listing and line listing contents	
9	Staff should assist residents in performing **hand hygiene**: • Before / after meals • After contact with bodily fluids (cough, sneeze, bathroom) • Before / after leaving room • Before / after group activities	
10	Begin proactive **contact tracing** if a case is suspected in the home See Sample Contact Mapping and Timeline Tool Note: Public Health will assist with this, but the facility can minimize further spread by proactively identifying staff and residents who have had close contact with the individual and taking necessary precautions. See here for more information.	
11	There have been several cases of symptomatic residents who have tested negative initially and then tested positive after several swabs. Residents should be isolated while they remain symptomatic even after a negative swab.	
12	Suspected case **communication** protocols should be initiated	

* In smaller LTCH where it is not possible to maintain physical distancing of staff or residents from each other, all residents should be managed as if they are potentially infected, and droplet and contact precautions should be used when in an area with a positive case.

5.2.1 RESIDENT ISOLATION PROTOCOLS

#	Steps to implement	Done
1	Place in **single room** if not already	
2	Put in **droplet and contact precautions** (See Droplet and Contact Precautions Fact Sheet)	
3	Place **signage** and **PPE** outside the room	
4	**Notify** Charge Nurse, IPAC officer or DOC	
5	**Explain isolation procedures** to resident	
6	**Communicate** with rest of staff in unit / floor to ensure ongoing monitoring and precautions are followed	
7	If resident needs to be moved, give them a **mask**	

5.2.2 WORK SELF-ISOLATION FOR STAFF

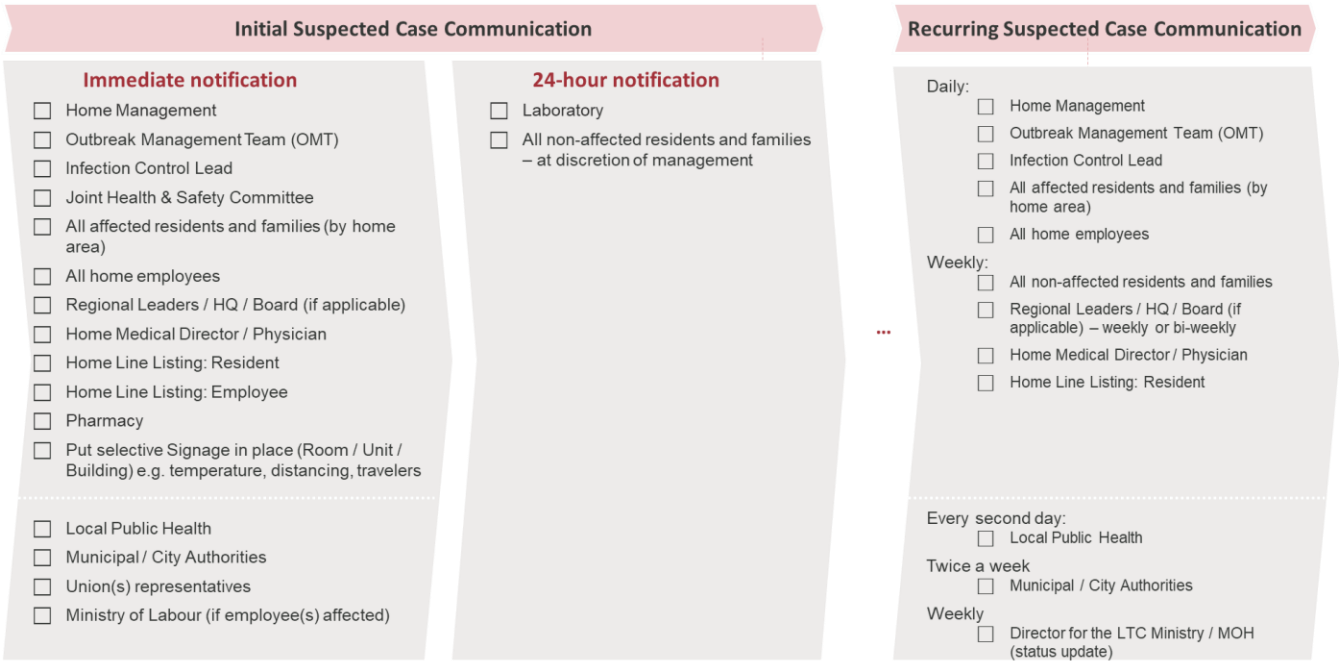
In **exceptional circumstances**, asymptomatic staff critical to operations, but who were advised to isolate, may continue to work while using appropriate PPE and undertaking active self-monitoring. They should **immediately self-isolate if symptoms develop**.

- **Inform Occupational Health and Safety** before undertaking work self-isolation
- Outside the workplace, staff must follow **self-isolation** recommendations
- Work self-isolation should last **10 days** from return from last unprotected exposure to an infected person
- At a minimum, a **mask should be worn at all times**, including in public transit
- **Contact and droplet precautions** should be used when providing direct care
- Staff should maintain **physical distancing** except when providing direct care
- Meticulous **hand hygiene** is required
- **Meals** should not be eaten in a space shared with other staff or residents
- As much as possible, staff in self-isolation should work with a limited number of residents, ideally being cohorted to **provide care for residents who are confirmed cases**

Additional information can be found on PHO's work self-isolation fact sheet.

5.2.3 SUSPECTED CASE COMMUNICATION

Any Suspected Case should drive clear and transparent communication with numerous stakeholders, both internal and external. The overview below shows key elements of communication: some are immediate, others should be executed within 24 hours. With a Suspected Case, there should be frequent, regular communication as well to keep different parties informed.



Please refer to the Leadership section for detailed Communication guidance. Several suggested communication templates can be found in the Appendix.

5.3 TESTING

WHEN TO PERFORM TESTING

Testing may be required under different circumstances:

- A test is to be administered as soon as a resident is experiencing symptoms / has failed a screening.
- For staff who fail a screening and present symptom, the home should facilitate testing by directing them to an assessment center or appropriate location for testing as soon as possible.
- Under instruction by local Public Health, testing may be done for all residents and staff of a home at once. LTCH are to follow guidance from their local PHU about test procedures.

WHO SHOULD BE TESTED?

Given an overabundance of precaution, the threshold to test residents and staff in LTCH is low. Note that guidance around testing is constantly evolving – please confirm with official ***COVID-19 Provincial Testing Guidance Update.***

No Outbreak	Outbreak

• Any resident or staff who is symptomatic / has failed a screening (including deceased residents who were not previously tested) • Residents who were in close contact (e.g. shared room) with the resident who has failed a screening • Anyone else deemed high risk by local public health unit	In an outbreak, the following individuals should be tested, whether they are symptomatic or not: • All residents living in adjacent rooms to a positive case • All staff working on the unit /care hub • All essential visitors that attended at the unit / care hub • Any other contacts deemed appropriate for testing based on a risk assessment by local public health

HOW TO COMPLETE TESTING

Homes should request testing from their local PHU. They will provide additional guidance as to how to perform testing and provide testing kits if required. Once a sample has been collected, the following steps are required:

- Ensure "Institution" is marked under the "Patient Setting" section of the laboratory requisition to prioritize testing
- Indicate outbreak number obtained from the PHU if an outbreak has been declared
- If submitting for staff, indicate "Healthcare Worker"

For staff testing outside the LTCH (e.g. at an assessment center), they should be given the outbreak number if available.
COVID-19 PHO Requisition Form: https://www.publichealthontario.ca/-/media/documents/lab/2019-ncov-test-requisition.pdf?la=en

CONSIDERATIONS FOR TESTING

Given delays between initial swab and receiving test results, it is recommended to implement additional precautions following testing to avoid infection between swab and results. This is especially important in the event an entire facility is being tested, as droplet/contact precautions will not be in place for asymptomatic individuals. Additional precautions include:

- Cohorting staff to ensure they only work with specific residents
- Enhanced hand hygiene
- Having residents stay in their room as much as possible

RECEIVING RESULTS

The home will receive results for all residents for whom it requests a test. Local PHU will inform the home if a staff tests positive.

Negative	Positive

• If all those tested receive negative results and no further testing is deemed necessary by the local PHU, the LTCH can end the suspect outbreak assessment related steps. • If the resident presented symptoms, testing for relevant conditions should be performed and outbreak protocols should still be followed (e.g. isolation, PPE, etc.) • For residents presenting no symptoms, isolation and droplet/contact precautions may be stopped	• For positive results, the home should follow directives from the local PHU (additional testing, outbreak area, etc.) • Outbreak recognition, Isolation / Suspected case and Confirmed case protocols should be followed • Positive results are considered a confirmed case even if the individual is asymptomatic

Note that a **negative test does not rule out the potential for the individual to still be incubating** the illness. It is recommended that any resident still presenting symptoms after testing negative remain in isolation while symptomatic, and those who have had close contact remain in isolation for 14 days following the last unprotected exposure. As such, residents and staff who initially test negative may need to be retested if they develop symptoms.

COMMUNICATION

Conducting testing is one of very important activities within a pandemic and it requires dedicated communication. Please find below a list of all stakeholders that need to be informed about testing, both at the beginning and upon test completion.

Initial Test Communication	End Test Communication
☐ Home Management	☐ Home Management
☐ Outbreak Management Team (OMT)	☐ Outbreak Management Team (OMT)
☐ Infection Control Lead	☐ Infection Control Lead
☐ Joint Health & Safety Committee	☐ Joint Health & Safety Committee
☐ All residents and families	☐ All residents and families
☐ All home employees	☐ All home employees
☐ Regional Leaders / HQ / Board (if applicable)	☐ Regional Leaders / HQ / Board (if applicable)
☐ Home Medical Director / Physician	☐ Home Medical Director / Physician
☐ Home Line Listing: Resident	☐ Home Line Listing: Resident
☐ Home Line Listing: Employee	☐ Home Line Listing: Employee
☐ Local Public Health	☐ Local Public Health
☐ Municipal / City Authorities	☐ Municipal / City Authorities
☐ Union(s) representatives	☐ Union(s) representatives
☐ Ministry of Labour (if employee(s) affected)	☐ Ministry of Labour (if employee(s) affected)
☐ Local Public Health	☐ Local Public Health
☐ Municipal / City Authorities	☐ Municipal / City Authorities
☐ Hospital Emergency Department / Paramedics	☐ Hospital Emergency Department / Paramedics
☐ LHIN	☐ LHIN
☐ Union(s) representatives	☐ Union(s) representatives

5.4 CONFIRMED CASE

A confirmed case is to be handled in the same way as a suspected case for both staff and residents (See 5.2 SUSPECTED CASE), with the exception that at this stage, cohorting of resident and staff may change:

- Once a resident is confirmed positive, they may be moved to a different location to facilitate cohorting of positive residents together
- Staff should be reassigned to only care for positive OR negative residents if possible

Note: Cohorting measures will differ based on the number of residents – see 5.6.3 OUTBREAK SCENARIOS for different Outbreak Scenarios.

Once a case is confirmed, timely and transparent **communication** with residents and their families is critical. In addition, communication with staff, the media, authorities, and all other relevant parties should be a priority.

Once a home has a single positive case in a staff or resident, they will be declared in outbreak, as outlined in the following sections.

5.5 DECLARATION OF OUTBREAK

Long-term care homes must **consider a single, laboratory confirmed case of COVID-19 in a resident or staff member as a confirmed respiratory outbreak** in the home. Outbreaks should be declared in collaboration between the home and health unit to ensure an outbreak number is provided. See PHO Checklist for COVID-19: Infection Prevention and Control for additional information and updates.

#	Steps to implement	Done
1	**Local Public Health Unit is notified** immediately by Infection Prevention and Control Officer or designate of a suspected case and will work with the LTCH to determine whether an outbreak should be declared.	
2	Once an outbreak has been declared, residents, staff or visitors, who were in **close contact with the infected resident**, or those within that resident's unit/hub of care, should be identified and tested.	
3	Once an outbreak is declared, the following measures must be taken: • **New admissions and re-admissions are not permitted** • If a resident leaves the home for an **outpatient visit**, the home must mask the resident and screen them upon their return • Residents who are **taken out of the home by family** may not return until the pandemic is declared over • **Discontinue all non-essential activities**, if not already stopped (e.g. pet visitation programs)	
4	**Define the outbreak area** (e.g. affected unit(s) vs. whole facility) - there should be a discussion between the Medical Officer of Health or designate and the LTCH regarding whether to declare a facility-wide outbreak or an outbreak confined to one or more units when the cases are on one or more unit/floor and can be confined to those units/floors.	
5	**Post Outbreak signage** outside the home / outbreak area	

#	Steps to implement	Done
6	**Outbreak communication** protocols should be initiated	
7	Consider the possibility of **high absenteeism** in the event an outbreak is declared. Ensure HR contingency plans are in place and HR is available to support department leaders in responding to shortages.	

5.6 OUTBREAK MANAGEMENT

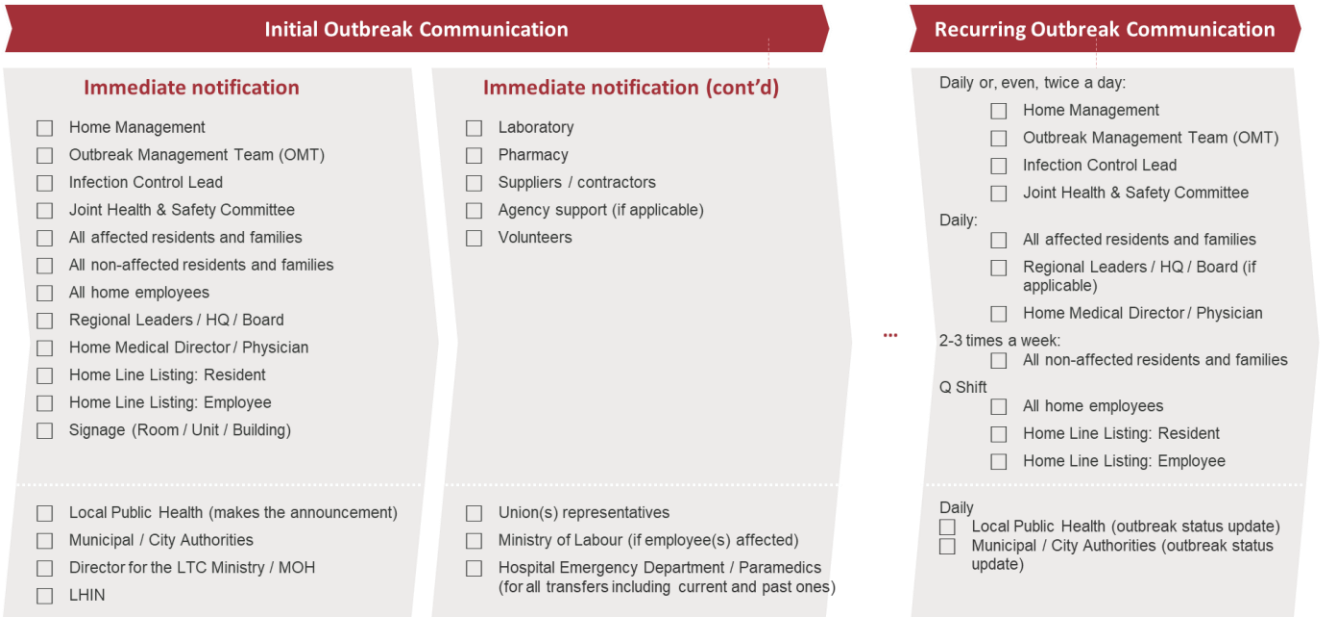
An outbreak is the most challenging part of a pandemic for the home, its staff and residents. It must be managed according to a clear set of rules and guidelines – this chapter provides an overview of many of them including established best practices.

5.6.1 OUTBREAK: IMMEDIATE ACTIVITIES

#	Steps to implement	Done
1	All **residents in the outbreak area are to be considered either infected or suspected** of being infected. All procedures established for a suspected case and prevention still apply: • Resident to isolate in their room within the outbreak area • Applies to all residents in the outbreak area • Positive residents should not be in a shared room with a negative / unknown resident – use privacy curtains pending move • In-room tray service for all unit / home area in outbreak • Staff isolation at home • Contact and Droplet precautions (plus Airborne if AGMP) • Staff cohorting to unit / positive home area • Universal masking • N95 masks when providing care to high risk or confirmed COVID-19 cases • Essential visitors only	
2	**Droplet/Contact precautions** remain in place until there have been two (2) negative specimens taken 24 hours apart OR if testing for clearance is not feasible, Droplet/Contact precautions remain in place for 14 days after the onset of symptoms.	
3	**Maintain line listing** for all known and suspected cases	
4	Once an outbreak has been declared, residents, staff or visitors who were in **close contact** with the infected individual(s) should be identified and tested, if not already completed	
5	Ensure **outbreak number is provided to staff** who seek testing	
6	**Cohort positive residents** if more than 1 positive case: • Where possible, relocate residents to adjacent rooms; consider alternative options such as relocating negative cases, using other purpose rooms in the home, dedicating entire units, or sharing rooms for positive residents • Assign staff to work only with positive residents across all functions	
7	Staff who have had **high risk exposure** to the resident without proper PPE should **self-isolate** for 10 days or until they can be tested	

5.6.2 OUTBREAK COMMUNICATION

During an outbreak it is essential for there to be clear and transparent communication for all stakeholders (internal and external). The overview below breaks down communication into initial and recurring communication. Please note that one standard letter announcing the outbreak can be used for several stakeholders (e.g. suppliers, agency support, volunteers, union(s) representatives, Ministry of Labour, etc.)



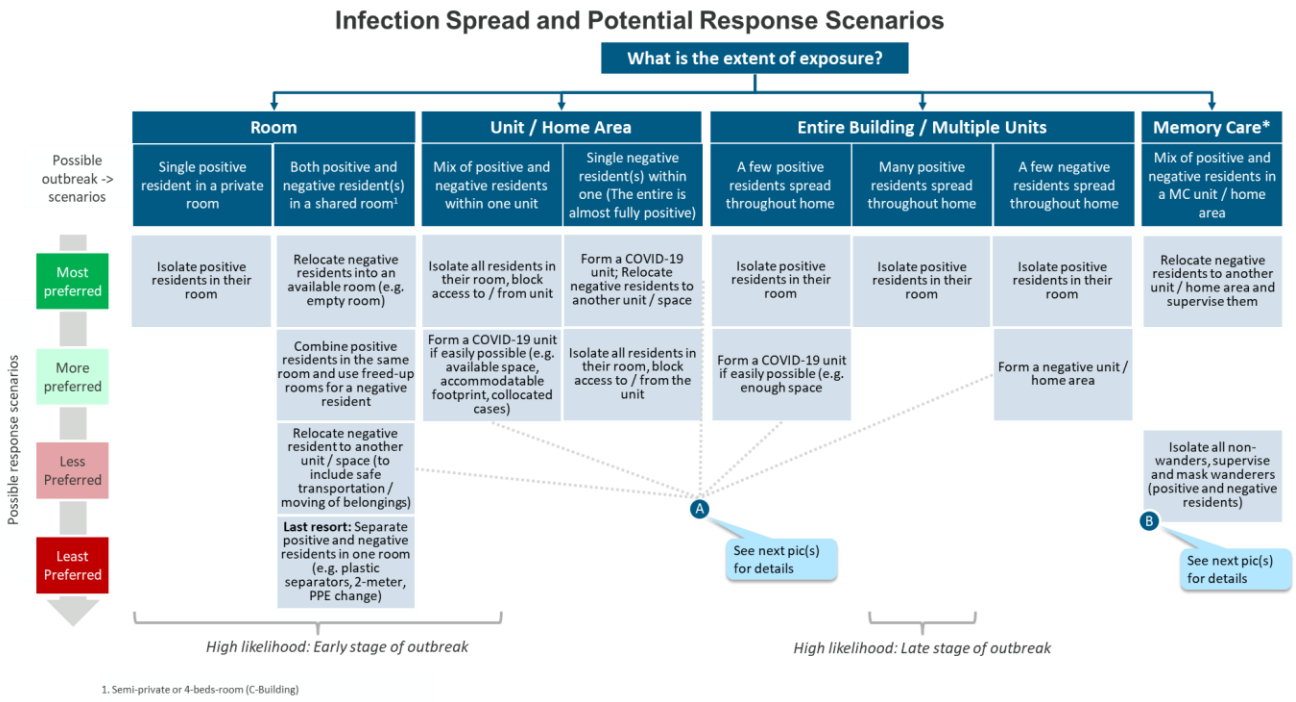
Please refer to the Leadership section for detailed Communication guidance. Several suggested communication templates can be found in the Appendix.

5.6.3 OUTBREAK SCENARIOS

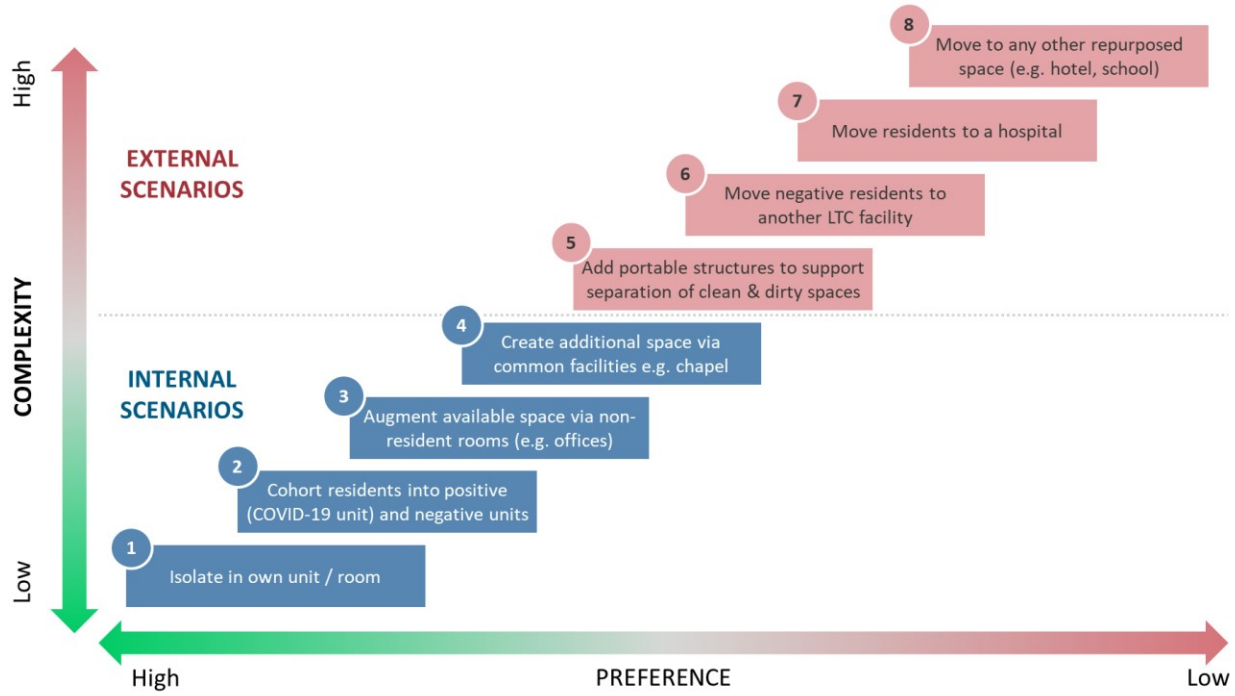
Based on test results, multiple outbreak scenarios should be considered. These are defined by the following three criteria:

- Who tested positive: employees, residents, both?
- What is the scope of the outbreak within the home: one room (e.g. single resident), one unit/home area, entire building?
- Are Special Care residents impacted?

Based on these factors, a set of possible outbreak scenarios and ways to handle them has been developed. These are shown in the overview below.



Depending on home format and the nature of the outbreak (e.g. single resident vs numerous residents) there might be a need to create additional space. An overview below shows a range of options to provide additional accommodation space, from most preferred to least preferred.



The below overview shows the complexity (e.g. associated logistics, negative impact on resident, associated resources) and preference (e.g. most preferred vs less preferred) for each scenario and additional information below is intended to inform decision-making.

Scenario	Key considerations	Feasible scenarios to use
1 Isolate in own unit / room	• Easiest to implement, does not require moving residents • Requires staff cohorting • Any staff entering room to have complete PPE, donning/doffing • Most preferred option recommended by authorities • Assumes availability of available rooms if some positive residents are in shared rooms	• Single positive cases • All cases can be localized within one or few units • Facility-wide outbreak AND there are enough rooms for all positive residents
2 Cohort residents into positive (COVID-19 unit) and negative units	• Requires safe moving residents through the building • Harder to implement (e.g. need to transport residents' belongings, resident-specific equipment e.g. O2) • May cause agitation of residents	1. Several positive residents spread throughout the building. 2. Critical mass of positive residents within one unit (e.g. not 1-2 but 5-10 positive residents on one unit)
3 Augment available space via non-resident rooms (e.g. offices)	• Typically done within the same unit where positive residents are located • Types of space to be leveraged: offices, meeting room, rec room) • Requires some preparation (e.g. taking out existing furniture, adding beds, mattresses) • Requires safe moving residents through the unit • May cause agitation of residents	1. A mix of positive and negative residents within one room AND lack of space to separate them 2. Need to increase the COVID-19 unit to accommodate additional few residents
4 Create additional space via common facilities e.g. chapel	• Leveraging larger common spaces e.g. chapel, event hall, library • Requires advanced preparation (e.g. adding electrical outlets, remote bell system, taking out existing furniture, adding beds	1. High number of positive residents throughout the building and lack of individual rooms to isolate them (e.g. many shared rooms)

	and mattresses, ensure there are red plugs connected to generator) • Requires safe moving residents and their belongings through the building • May cause agitation of resident • Requires additional staff	
5 Add portable structures to support separation of clean & dirty spaces	• Typically, non-resident structures to be added outside of the building e.g. laundry, kitchen • Supports separation of space into "clean" and "dirty" spaces • Requires external support e.g. city, army • Allows to enhance the LTC building footprint	1. Lack of ability to separate existing footprint into "clean" and "dirty" areas / too small existing support footprint (e.g. kitchen, laundry, storage, etc.)
6 Move residents to a hospital	• Requires coordination with a hospital • Number of topics to be addressed e.g. PPC data, moving of medications • Requires safe transportation of residents and their belongings	1. High number of positive residents throughout the building and lack of any space to isolate them (e.g. many shared rooms) AND/OR 2. Dramatic lack of personnel
7 Move negative residents to another LTC facility	• Requires cross-facility to coordination e.g. may require Letter of Understanding • In most cases works for organizations that have multiple LTC facilities in proximity • Number of topics to be addressed e.g. PPC data, moving of medications • Requires safe transportation of residents and their belongings • Potentially, moving of some staff, familiar to residents	1. A limited subset of negative residents (need to be firmly validated) who can be moved AND ability of space / staff / isolation opportunities in another LTC home.
8 Move to any other repurposed space (e.g. hotel, school)	• Requires coordination with municipal authorities • Assumes use of available, repurposed space (e.g. schools, universities, public libraries, etc.)	1. Last-resort scenario when any other health services providers (LTC homes, hospitals) are not available AND staying in the current LTCH home is not an option.

	• Requires advanced preparation (e.g. adding electrical outlets, remote bell system, taking out existing furniture, adding beds and mattresses) • Requires safe transportation of residents and their belongings • Potentially, moving of some staff, familiar to residents • Will require additional staffing	

Low preference options are to be considered only when all higher preference options cannot be used. The primary decision-criteria in this situation is health and well-being of residents and staff.

5.6.4 CLEARING CASES

There are two approaches to clearing cases (determining a confirmed case is resolved). LTCH should always follow guidance from their local PHU to determine which is most appropriate.

	Non-test based approach	Test based approach
Description	Waiting 10 days from symptom onset or swab date if persistently asymptomatic	Two consecutive negative specimens collected at least 24 hours apart
Recommended use	All cases may be cleared with this approach	Not routinely recommended, but may be used at the discretion of a hospital to discontinue precautions for admitted patients
Instructions	Discontinue isolation 10 days after symptom onset or swab date if never had symptoms, provided that: • Individual is afebrile • symptoms are improving for at least 72 hours* *Absence of cough not required for those known to have chronic cough or are experiencing reactive airways post-infection.	Continue isolation until 2 consecutive negative specimens collected at least 24 hours apart • Testing may begin after the individual becomes afebrile and symptoms improve* • If swab remains positive, test again in 3-4 days. If negative, re-test in 1-2 days • Tick box labeled 'For clearance of disease' in the PHO Test Requisition form

From COVID-19 Quick Reference Public Health Guidance on Testing and Clearance Version 15.1 – Sept 14, 2021

Note that until more is known on the virus, people who have recovered from COVID-19 are not considered protected from a second infection. See WHO Scientific Brief on the topic.

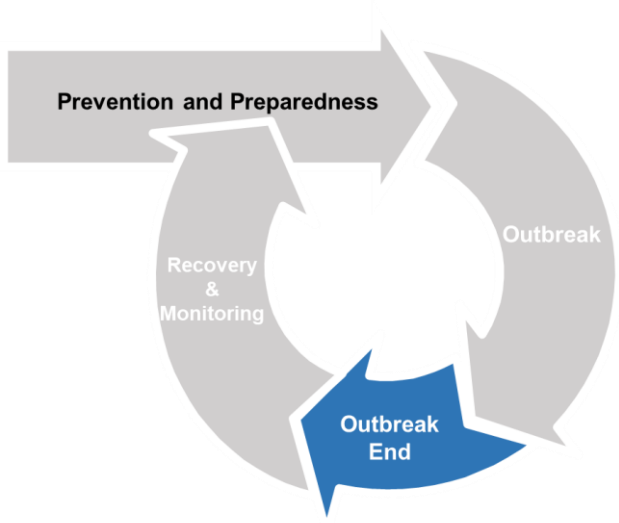
5.6.5 RETURN TO WORK

If COVID-19 is suspected or diagnosed in a staff, return to work should be determined in consultation with their health care provider and the local public health unit. Staff must report to the Occupational Health and Safety committee or representative prior to return to work. Generally, **only staff who are asymptomatic and have tested negative can return to work**.

COVID-19 Test result	Symptoms	Best Practice
Positive	Yes	• **Cannot attend work while symptomatic** • Work self-isolation could begin 72 hrs after resolution of fever and improvement in respiratory and other symptoms
Positive	Never symptomatic at time of test	• Positive staff should not attend work for a minimum of 10 days • **Work self-isolation** could start after a **minimum of 72 hours** from the positive specimen collection date to ensure symptoms have not developed in that time
Negative	Yes	• **Cannot attend work while symptomatic** • May return to work **after symptom resolution** – see official guidance depending on symptom (e.g. 48 hours post-symptom resolution for gastric, 5 days post-symptom onset for respiratory) • If the HCW was self-isolating due to an exposure at the time of testing, return to work should be under work self-isolation until 14 days from last exposure

Source: MOH, COVID-19 Quick Reference Public Health Guidance on Testing and Clearance, Version 15.1 – Sept 14, 2021

5.7 OUTBREAK END



This section outlines the best practices and guidelines that all staff should be familiar with as it relates to the end of an outbreak.

The end of an outbreak typically marks a transition period between outbreak practices and recovery / prevention practices. It is critical here to remain vigilant, as well as capture lessons learned from the outbreak.

5.7.1 OUTBREAK END: IMMEDIATE ACTIVITIES

#	Steps to implement	Done
1	In collaboration with local PHU, outbreak may be declared over when there are no new cases in staff after **10 days from the latest of**: • Date of isolation of last resident case • Date of illness onset of last resident case • Date of last shift at work for last staff case	
2	**Remove outbreak signage**	
3	**Outbreak end communication** protocols should be initiated, and Prevention communications may resume until the pandemic is declared over	
4	Schedule time with key staff to review outbreak management and capture **lessons learned**. Update relevant documentation.	

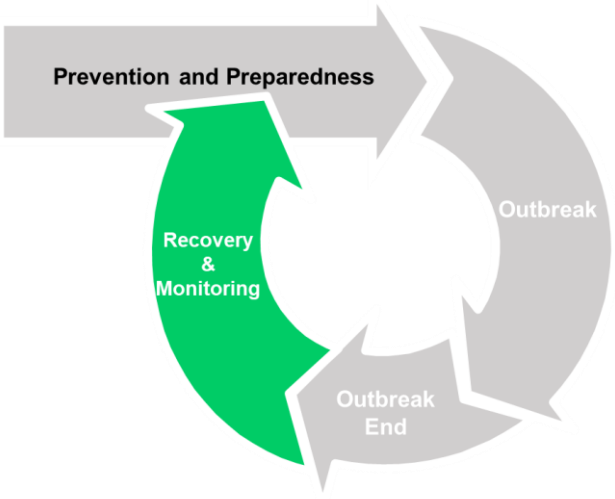
Note that until more is known on the virus, people who have recovered from COVID-19 are not considered protected from a second infection. See WHO Scientific Brief on the topic.

5.7.2 OUTBREAK END COMMUNICATION

Outbreak end should drive clear and transparent communication with numerous stakeholders, both internal and external. The trigger for the Outbreak End is typically a decision by the Public Health Unit.

Please refer to the Leadership section for detailed Communication guidance. Several suggested communication templates can be found in the Appendix.

6 RECOVERY AND MONITORING



This section outlines the best practices and guidelines that all staff should be familiar with for Recovery and Monitoring post-outbreak.

It is important to note that Recovery and Monitoring measures go hand in hand with Prevention and Preparedness measures so that the home(s) minimizes the chance of future outbreaks, while being prepared were they to occur.

This chapter is intended to be shared with the entire long-term care home team to ensure that there is a broad awareness of all Recovery and Monitoring measures.

It can be challenging to predict how long a pandemic may last, with pandemics in recent history spanning a few weeks to months, and others stretching over a year, especially if a vaccine or treatment does not exist. The below outlines the entire period between the end of an outbreak and the end of a pandemic.

In this phase, ongoing monitoring of the situation takes a critical role in recovery, as any changes in the home situation (e.g. new positive or suspected cases) should be tracked closely. Below is a high-level overview of required changes across various functions.

Topic	Key changes
Resident and their Families	• Gradual decrease in isolation / separation measures while ensuring safety and well-being of residents (e.g. more activities, group activities, etc.) • Permission to visit (follow government guidance) considering safety aspects (e.g. distancing, protective equipment)
Clinical and Care	• Ensure safe means for delivery of care embedding prevention and preparedness best practices into everyday operations, e.g. • No staffing across multiple homes • Maintaining some cohorting rules if meaningful • Supply management precautions • Ensure availability of necessary supplies for possible future waves of outbreak (especially PPE)
External Resources	• Ensure ability to operate in self-sufficient mode (e.g. without hospital, army or volunteer resources that might have provided temporary support) • Adjust procedures to interact with external service providers and suppliers to reduce potential risk to residents and staff • Explore virtual options for some services that do not require in person presence (e.g. training)
Monitoring	Close monitoring of pandemic situation on multiple levels: • Home-level (e.g. suspected cases, symptoms, other indicators) • Community / Regional level (e.g. suspected / positive cases, new deaths, geographical infection spread, other indicators including trends) • National Level (e.g. suspected / positive cases, new deaths, geographical infection spread, travel restrictions/limitations, other indicators including trends) • Worldwide (e.g. suspected / positive cases, new deaths, geographical infection spread, travel restrictions/limitations, other indicators including trends)
End of pandemic	There are several potential ways a pandemic could end; this can be hard to predict. The most likely scenario at this stage is based on availability of a proven vaccine or treatment, and the ability to protect both residents and staff members making them immune to the disease. It is important to make sure that public guidance through authorities is closely followed and this playbook updated accordingly.

7 FUNCTION-SPECIFIC PROCEDURES

7.1 HR

Several homes have experienced severe staffing challenges throughout the pandemic, both among staff and leadership. Prevention activities have increased staffing requirements, while at the same time sick leave and work refusals have increased. HR plays a critical role in sustaining care levels and employee health and safety in the home. In order to address staffing shortages, in addition to preparing and implementing contingency plans, HR should:

- Work closely with all functions to understand hiring needs and ramp up hiring
- Work with all functions to support cohorting
- Accelerate onboarding processes while maintaining quality
- Focus on ensuring staff return to work as soon as safely possible and following return to work protocols
- Manage and mitigate Work Refusals

A toolkit was prepared to assist LTCH with Return to Work, including for non-COVID reasons.

#	Steps to implement	Done
P1	Develop / review contingency plan to: • Identify minimum staffing needs for each area • Prioritize critical and essential services based on resident population needs	
P2	Consider implementing a Universal model of care: • When residents do not require hands-on care, other tasks such as cleaning and disinfecting within the home area should be assigned to PSW • RN to be seen as a specialist, serving all home areas and use a full set of PPE when entering the home area (consider virtual approach as well)	

#	Steps to implement	Done
	• Same applies to any other specialist (e.g. social worker(s), physiotherapist, etc.)	
P3	Create contingency plan for leadership in the event that several critical roles can no longer attend work due to illness or other reasons and critical leadership gaps exist. This may require discussions with municipality, local hospitals and other institutions.	
P4	Fill as many vacancies as possible prior to being in outbreak and hire to fill gaps across all areas as established in contingency plan	
P5	Monitor government directives that impact staff, compensation, schedules, etc., as well as any other programs that offer staff support (e.g. CaRES, emergency childcare). Communicate as appropriate	
P6	Collect information from staff, contractors and volunteers about: • Availability • Likely or actual exposure to the disease • Health conditions that may affect their availability to provide services	
P7	Review staffing schedules, availability of alternate staff and emergency contact numbers for staff	
P8	Provide guidelines for staff cohorting and train department leads	
P9	Work with Department leads to: • Increase staffing to support additional requirements / surge capacity • Create contingency plans • Implement staff cohorting • Determine who should work from home • Ensure schedule is in compliance with latest orders (e.g. no staff work in more than one home) • Improve employee engagement and morale	
P10	Redeploy staff who work in non-essential / suspended services (e.g. hair salon staff as screener, EAs to be family contact, community programs for PPE sourcing, etc.)	
P11	Discuss with unions to align on pandemic needs and procedures, for example, to review of compensation from hourly to salaried pay for the pandemic period	
P12	Consider creating temporary Full-Time (FT) position with all employees that are currently Part-time (PT) or casual. If it is not possible to create a temporary FT position, limit PT resources to one home area/floor as much as possible.	
P13	Closely monitor absenteeism and adjust staffing plans accordingly See HR Recommendations for Work Refusals	
P14	Identify all available options to meet staffing needs, including: • Health Workforce Matching Portal • Volunteers • Agency contracts • Health Unit support • Local healthcare facilities (e.g. hospital) • Emergency services (e.g. army) • Recruit college / university students, individuals from other sectors (e.g. hotels, restaurants) • Cross-training / universal roles (e.g. housekeeping and tray delivery) • Look at staff history (e.g. PSWs who were housekeepers) and how can leverage cross-skilling	

#	Steps to implement	Done
	In addition, consider accelerating onboarding process.	
P15	Put in place initiatives to prevent high absenteeism in the event of an outbreak including: • Recognize employees' hard work often • Check-in with staff • Organize engagement activities (e.g. sidewalk chalk messages, team video, etc.) • Ensure staff are aware of EAP and other resources available for their wellness • Mitigate staff fears by communicating protection measures taken / to follow	
P16	Review sick leave policy and potentially adjust for COVID to discourage people coming to work while sick	
P17	Ensure Return to Work protocols are in place and being followed	
P18	Consider creating plans to offer staff hotel accommodation, transportation subsidy, grocery delivery, etc. to minimize community risk if transmission is widespread in municipality / region	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Place enhanced focus on employee engagement and morale	
O3	Ensure staff is cohorted to care only for ill or well residents	
O4	If using emergency staffing (e.g. army, hospital staff), discuss timeline for availability, create a plan to self-sustain staffing needs and continue recruiting	
O5	Continue hiring to fill needs (if applicable)	
O6	Focus on Return to Work to get staff back to work as soon as safely possible	

7.2 HEALTH AND SAFETY

#	Steps to implement	Done
P1	Follow up with any staff who has failed a screening	
P2	Review list of staff who called in sick in the previous 7 days. Work with your PHO liaison to ensure any who are still symptomatic get testing.	
P3	Inform the Infection Control designate of any cases or clusters of staff including who are absent from work	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	If an employer is advised that a **worker has tested positive for COVID-19 due to exposure at the workplace**, or that a claim has been filed with the Workplace Safety and Insurance Board (WSIB), the employer is required to notify: • The **Ministry of Labour, Training and Skills Development** (MLTSD) in writing within four days • The workplace **Joint Health and Safety Committee** or a health and safety representative • A **union** (if applicable) • Any instances of occupationally-acquired infection shall be reported to **WSIB** within 72 hours of receiving notification of said illness. Employers do not need to notify the ministry if a worker has contracted COVID-19 outside of the workplace. Note: The Ministry of Labor is not currently limiting workplace illness claims to outbreak homes given the challenges posed in determining how infection happened due to asymptomatic cases. Subsequent investigation and testing in collaboration with the local PHU will establish whether it was likely the infection was acquired at work	

7.3 CLINICAL AND NURSING

7.3.1 IMMEDIATE NURSING TASKS FOR POSITIVE / SUSPECTED CASE

Please note that the tasks in the list below should be implemented immediately upon identification of a positive resident or a resident exhibiting signs and symptoms as related to the pandemic. These activities are critical and determine the success of dealing with the outbreak.

#	Steps to implement	Done
O1	Screening and documentation of temperature, signs and symptoms	
O2	Inform resident immediately that they will be place under precautionary isolation when a resident presents signs and symptoms	
O3	Put key precaution measures in place: lift droplet precaution, visual poster, isolation PPE bin outside of room	
O4	Advise all employees/departments as to signs and symptoms and of the additional precautions in effect.	
O5	Ensure proper PPE are sufficiently stock at resident door.	
O6	Communicate findings with DOC/DON, Outbreak Management Team (OMT).	
O7	Obtain from Environment Services disinfection chemicals.	
O8	Ensure that family members are notified	
O9	Add to EHR Home page: resident room number, name placed on isolation	
O10	Document progress notes twice per shift	
O11	Instruct staff on the home area to immediately initiate a full unit top surface disinfection. • Including all high touch surfaces • Progressively moving out to the whole building especially dining room and elevators. Med cart and the resident's floor started. Disinfect from cleanest area and work their way towards the resident's positive door.	
O12	Ensure residents on the unit hands are washed or sanitized.	
O13	Encourage all residents on the unit / home area to wear a mask, if tolerated.	
O14	Notify Kitchen about disposable tray.	
O15	Notify PSW who cared for the resident 72 hours prior for screening • Ensure that PSW goes to get swabbed	
O16	Add resident / staff to line listing (including those in close contact with positive resident)	
O17	Coordinate with Public Health Unit (PHU) for swabbing	
O18	Notify MD of signs and symptoms, obtain orders for comfort management including oxygen.	
O19	Initiate cohorting of PSWs who care for resident with positive signs and symptoms (if not already in place)	
O20	Review with staff hand washing procedure, downing and doffing of PPE	
O21	Review the Resident Health Status and add to Care plan the presence of infection signs and symptoms.	
O22	Monitor resident condition every 2 hours during the shift and ensure that all areas of care needs are continuously met.	
O23	Notify Pharmacy of positive case.	

7.3.2 CHANGES IN REGULAR NURSING ACTIVITIES

#	Steps to implement	Done
P1	Ensure that nursing staff is working for one facility only and is not engaged in other homes	
P2	Cohort staff by unit / floor or cohort staff (both clinical services and care) to only work with specific groups of residents as much as possible	
P3	Registered staff may need to cover more than one unit / home area: • RN to act as an expert across all units / home areas; full set of PPE change when entering a unit / home area • RPNs to act as an expert across more than one unit / home area (e.g. on one floor); full set of PPE change when entering a unit / home area	
P4	Consider creating temporary Full-Time (FT) position with all nursing employees that are currently Part-time (PT) or casual. • If it is not possible to create a temporary FT position, ensure that a PT resource is assigned to one home areas only.	
P5	Implement enhanced universal precautions: donning and doffing complete PPE in- between residents, even when they are in semi-private room.	
P6	2 PPE carts in place in semi-private units; 4 PPE carts in place in 4-bed units	
P7	If possible, work with pharmacy to enable waiting time for medications / ensure that there are enough medication supplies • E.g. ordering in advance • Ensure that government medication supply has enough supplies to cover 3-day of unexpected changes to treat all COVID-19 symptoms (e.g. Tylenol, etc.).	
P8	Regular risk assessment in the community to include resident acuity such as CPAP, 15 ml / O2 per minute (require N95 mask) as per Public Health.	
P9	Review residents' medication schedule to minimize the number of times staff need to enter the room. Examples include: • Switching medications to less frequently dosed formulations or reducing dosing frequency, if safe • Reassessing non-standard medication administration times • Aligning medication administration times to coincide with timing of other resident care tasks • Reassessing the need for non-essential medications • Reassessing the use of nebulizer therapy, as applicable	
P10	Ensure that nursing staff is trained on NP swab collection and proper line listing procedures	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Ensure that all activities from the previous section IMMEDIATE NURSING TASKS FOR POSITIVE / SUSPECTED CASE are in place	
O3	Isolate residents exhibiting any COVID-19 symptoms, and other residents as instructed by local Public Health Unit (PHU), and put in place appropriate additional precautions • Droplet and contact precautions: surgical mask; isolation gown; gloves; eye protection • Aerosol protection (including aerosol-generating medical procedures e.g. suctioning, nebulizer treatments or high flow O2 treatments): N-95 mask as well as the other PPE	
O4	Supervise wandering residents in Special Care Unit	

#	Steps to implement	Done
O5	Use dedicated supplies for the rooms with a positive case • if there is not enough equipment available, any equipment used with the resident must be disinfected before leaving the room / being used on another resident	
O6	Log signs and symptoms	
O7	Initiate and update line list for staff and residents • Ensure line list is updated and sent to PHU every morning or as directed	
O8	Swab residents as instructed by Public Health Unit (PHU)	
O9	Put in place necessary Droplet and Contact Signage and PPE put in place	
O10	Hold huddles to communicate with the team	
O11	Close the fire doors to the entrance of the unit / home area and place outbreak signs. • Additional signs should be placed on any door that visitors or staff use.	
O12	Work with Public Health and Provincial directives to determine outbreak status	
O13	Conduct outbreak team meetings	

7.4 CARE

Important to know

- All positive residents (including suspected cases) to be handled in full PPE
- Staff to implement enhanced universal precautions: donning and doffing complete PPE in- between residents, even when they are in semi-private room.

7.4.1 IMMEDIATE PSW TASKS FOR POSITIVE / SUSPECTED CASE

#	Steps to implement	Done
O1	Ensure that primary care cohorting is in place	
O2	Review of resident and the preferred treatment to maintain comfort	
O3	Review proper hand washing, donning and doffing with Nurse	
O4	Initiate disinfection of top surfaces of resident room	
O5	If possible, immediately upon initiating the resident isolation, provide resident with full bath/shower including hair washing	
O6	Change bed sheets	
O7	Dispose of dirty laundry in laundry hazard bin in resident room	
O8	Perform all resident care ensuring leaving the resident comfortably in bed or preferred area in their own suite with call bell accessible – Suggested visual monitor	
O9	Push and document fluids intake	
O10	Support Resident through meaningful activity of daily living.	
O11	Assist resident in Calling family / Face timing family	
O12	When out of the resident room, doffing appropriately, wash hands, dispose of the soiled PPE in the soiled utility room as frequently as possible, and disinfect visor or reusable goggles.	
O13	Employee caring for Resident should maintain strict physical distancing and use designated workstation for documentation of care.	

7.4.2 CHANGES IN REGULAR PRIMARY CARE ACTIVITIES

#	Steps to implement	Done
P1	GENERAL: Put in place cohorting for primary care providers	
P2	GENERAL: Support resident through meaningful activity of daily living. • Consider that in the pandemic situation residents might have less interaction with other residents and family members / loved ones • Residents may have increased feelings of anxiety, worry and frustration in the absence of visits from family and friends.	
P3	GENERAL: Assist resident in interaction by calling family or using other type of technology • This could be via phone, Microsoft Teams, Face Time, sending a photo, or writing a letter. • Some residents may find video calls or window visits distressing if unable to understand why they can hear but not physically touch their loved one.	
P4	TRANSPORTATION / LIFTING: All transportation devices / equipment including lifts to be disinfected after each use	

#	Steps to implement	Done
P5	PERSONAL HYGIENE: Separate all personal items for each resident for the duration of this pandemic • May require purchasing shelves or plastic baskets to ensure separation of personal hygiene products.)	
P6	PERSONAL HYGIENE: Adjust bathroom cleaning and disinfection approach • Disinfect bathroom and touchpoints pre-, and post-care, between each resident	
P7	LAUNDRY: Store clean linen and clothing in secure areas, without opportunity for cross-contamination. • Avoid linen storage in the resident room	
P8	LAUNDRY: Ensure that full PPE is worn when handling (open) soiled laundry, linen, and towels: gowns, goggles, gloves/face shield • Consider all soiled laundry / clothing as potentially infectious • Linen / clothing contaminated with blood or body fluids, should be considered contaminated, regardless of the known resident condition	
P9	LAUNDRY: Ensure that soiled laundry is placed in a plastic bag (i.e. leak-proof bags or containers) and hazardous laundry identified; transport in enclosed leak-proof bags or covered cart)	
P10	CLEANING: Develop a schedule for cleaning and disinfection of mobility equipment, personal assistance and support devices (PASD), and lifts	
P11	CLEANING: Ensure that staff is familiar with manufacturer's instructions for all products used and has been trained on the right cleaning / disinfection techniques • Existing staff • New staff (when joining the team)	
P12	CLEANING: Create a schedule for disinfection frequency of home area / unit	
P13	CLEANING: Create list of all high touch areas in the home area / unit and resident room, and assign responsible person for each • High-touch area - common areas: bed rails, door handles, light switches, handrails, chairs, faucets, elevator buttons, trolleys • High-touch areas – resident rooms: overbed tables, call bells, door handles, light switches, chairs, faucets	
P14	CLEANING: Clean and disinfect high-touch areas / surfaces: • High touch surfaces in resident rooms, washrooms, dining areas, public / common areas, staff areas, including equipment that moves around the home • Minimum twice daily frequency of cleaning/disinfection of contact surfaces with 1-min-kill-time e.g. Oxivir TB; ideally more frequent CLEANING: Clean and disinfect other areas / surfaces: • Normal frequency of cleaning/disinfection of contact surfaces with 1-min-kill-time e.g. Oxivir TB; normal hours	
P15	CLEANING: Put in place best practices for cleaning and disinfection of clothes Work clothes to be washed by the end of the day	
P16	WASTE MANAGEMENT: Ensure that staff is familiar with waste management handling and controls • Perform Hand Hygiene after handling waste; always use gloves • Watch for anything sticking out of the bag or waste containers	

#	Steps to implement	Done
	• Never dump waste from one receptacle/bag to another • Tie garbage bags before removing from the waste receptacle, never dump waste from one bin to another • Never reach into, or 'push' on the bag, to push the garbage down • Carry the garbage bag away from your body (hold bag by the knot/ties) If the bag of garbage is heavy and/or there is a chance the bag may break or leak, use a double/bag method	
P17	DINING SUPPORT: Support re-arrangement of the dining room layout to ensure physical distancing • Moving / adding / taking away tables and chairs • Remove everything from tables (e.g. salt and pepper shakers, other condiments, placemats, decorative items, etc.)	
P18	DINING SUPPORT: Support delivery of meals to the dining room Food transportation from the unit entrance to the dining room	
P19	DINING SUPPORT: Ensure that residents maintain 2-meter physical distancing before, during and after meals	
P20	DINING SUPPORT: Disinfect all surfaces between the sittings and after dining is completed • Includes tabletops, chair arms etc. • Sanitizers should be tested and recorded	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	INITIAL: Ensure that cohorting for primary care providers is in place	
O3	INITIAL: Isolate positive resident(s) including bed change and shower • if possible, immediately up on initiating the resident isolation provide resident with full in tub/ in shower full clean • Including washing of the hair • Change bed sheets	
O4	INITIAL: Educate primary care staff of PPE requirements, hand washing, donning and doffing for with suspected or confirmed cases (Contact and Droplet precautions)	
O5	INITIAL: Ensure doffing appropriately, wash hands, dispose of the soiled PPE in the soiled utility room as frequently as possible, and disinfect visor or reusable goggles.	
O6	INITIAL: Employee caring for resident should maintain strict physical distancing and used designate workstation for documentation of care.	
O7	INITIAL: Perform all resident care ensuring leaving the resident comfortably in bed or preferred area in their own suite with call bell accessible • Suggested visual monitor	
O8	INITIAL: Push and document fluids intake	
O9	INITIAL: Review of resident and the preferred treatment to maintain comfort	
O10	INITIAL: Initiate disinfection of top surfaces of resident room	
O11	INITIAL: Remove dirty laundry from the resident room in plastic bag identified as Contaminated laundry Handle with PPE.	
O12	CLEANING: Put in place a process to easily identify clean vs dirty equipment and rooms • Prevents staff from reusing equipment that has not been disinfected • Clean/dirty colored labels or elastic bands • Clean/dirty sections marked on the floor	
O13	CLEANING: Clean and disinfect all areas / surfaces:	

#	Steps to implement	Done
	• High touch surfaces in resident rooms, washrooms, dining areas, public / common areas, staff areas, including equipment that moves around the home • Includes but not limited to bed rails, door handles, overbed tables, light switches, call bells, handrails, chairs, faucets, elevator buttons, trolleys • Minimum twice daily frequency of cleaning/disinfection of contact surfaces with 1-min-kill-time e.g. Oxivir TB • Other areas / surfaces: increase frequency where possible	
O14	CLEANING: Clean and disinfect all areas / surfaces within 2 meters of the resident who is suspected / confirmed as soon as possible upon notification and on an ongoing basis.	
O15	CLEANING: Clean and disinfect resident room with active COVID-19 • Consider cleaning as the last room of the day • Consider what cleaning can be done by other team members who are having to enter the room for care and support.	
O16	DINING SUPPORT: Support tray service to the residents in their rooms including meal assistance and meals monitoring • Meal assistance to be provided in full PPE to the positive residents or those who are suspected • Residents never to eat alone • Residents who are able to eat on their own can receive meals in the doorway while the staff may monitor them from the hallway	

7.5 INFECTION PREVENTION AND CONTROL

#	Steps to implement	Done
P1	**Review existing policies and practices** and adapt as required: • IPC • Outbreak Management • Outbreak Management Team	
P2	**Track official directives** on a daily basis • Adapt signage if required • Adapt playbook, documentation and policies if required	
	Leverage **IPAC COVID-19 checklist** to assess readiness	
P3	**Implement directives and guidance** • Communicate to all relevant supervisors / leadership • Communicate to staff (both in person and in writing, include staff from all shifts) • Communicate with supply management designate if additional supplies are required	
P4	Perform **regular audit** for hand hygiene, respiratory etiquette, physical distancing, screening, PCRA (routine practices and Additional Precautions)	
P5	Ensure all **equipment is disinfected** between resident uses; implement new process if required	
P6	Work with residents and care staff to **enforce hand hygiene and physical distancing**	
P7	**Audit supply availability** (e.g. ABHR refilled, PPE at point of care, masks at entry)	
P8	Work with Education to provide **refresher training to all staff** on key Infection Prevention and Control and Outbreak Management practices	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Report regular updates to local PHU on ill residents or staff	
O3	Review IPC practices with all staff and perform regular audits	
O4	Participate in OMT meetings	
O5	Ensure staff are filling out line listing correctly – provide coaching as required	

7.6 FOOD SERVICES AND DINING

#	Steps to implement	Done
P1	Ensure that food supplies are planned and ordered according to the evolving pandemic needs • Ensure that supplies include light meal options (soup broth, ginger ale, jello, light meals) • Plan for a perpetual 7-day supply of paper disposables, cups, and cutlery • Trays and individual tables for in-room dining, carts	
P2	Any suspected case / isolated resident should be switched to tray service before an outbreak is declared	
P3	Plan for appropriate staffing when providing tray service – HR to support scheduling Anyone on tray service should be supervised at all times while eating	
P4	Implement clear rules for handling food supplies as they are delivered at the facility. All items should be disinfected. Best practice calls for implementing a waiting period to allow for surface decontamination, where feasible.	
P5	Work with Infection Control Coordinator to ensure any additional measures appropriate to cleaning routines and food handling practices are followed	
P6	Ensure that staff is trained on all necessary cleaning routines and food handling practices • Existing and new staff (when joining)	
P7	Review current dining room layout to ensure physical distancing • Preferred option: One person per table, minimum of 2 meters between tables, include multiple sittings if needed; rotate dining spots at the table for each sitting (e.g. rotate clockwise) • Alternative option: Two people per table, located as far as possible from each other, multiple sittings if needed; rotate dining spots at the table for each sitting (e.g. rotate clockwise) • Implement necessary changes e.g. adding tables, removing / blocking chairs, cohorting residents into different meal times • If dining rooms are shared by multiple floors / units, each sitting should be for a single floor / unit at a time. • If units / home areas use a shared dining room with a dividing, removable wall, it should be put out as a divider and locked in this position to convert one dining room into two separate ones • Remove everything from tables (e.g. salt and pepper shakers, other condiments, placemats, decorative items, etc.)	
P8	Ensure that food is delivered to the unit / home area in a safe way • A Dietary Aide (DA) should bring food to the home area but DA should not go into the home area • Food storage containers (e.g. Cambro) should be disinfected with 1 min kill-time (such as Oxivir TB) prior to taking it to the home area and prior to returning it to the kitchen • Ensure that a clean elevator / dedicated elevator is used to deliver food	
P9	Ensure that cooks and staff who manipulate and prepare food adhere to key rules • Use of a defined workstation	

	• Respecting the 2-meter physical distancing • Wear masks and gloves • No touching of food with their hands	
P10	Use disposable dishes • If this is not possible, dishes should be cleaned in the same unit where they were used • In the event dishwashing facilities are not located in the unit / home area, then the entire unit / home area should move to disposable dishes supplies	
P11	Disinfect all surfaces between the sittings and after dining is completed • Includes tabletops, chair arms etc. • Sanitizers should be tested and recorded	
P12	Work with HR to support employee morale	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	All residents in the unit / home area in outbreak to be moved to tray service in their room • All food to be provided in disposable containers / dishes • Positive residents to be served last (or by separate dedicated staff cohort) • Consider insulin dependent diabetics – do you need to work with the Nursing team to modify medication or offer tray service first • Ensure that all lids on snacks' disposable containers are loosened or removed where possible • Ensure sufficient staffing to help residents set up for eating (e.g. bib, transport assistance to doorway) • Ensure all residents can be supervised while eating – this may require staggered servings to ensure adequate coverage	
O3	Explore opportunity to provide Registered Dietitian's services remotely	

7.7 ENVIRONMENTAL AND HOUSEKEEPING

7.7.1 CLEANING AND DISINFECTING

Recommended products / tools					
Sample products / tools	*Oxivir TB AHP 0.5% (Saber)*	*PerCEPT Disinfecting Cleaner*	*Alcohol-based hand rub 70-90% e.g. Purell*	*Pulverized spray "Victory Complete"*	*ULV Fogger*
Typical use	Disinfection of all areas	Shoe disinfection e.g. when changing shoes	Hand disinfection at all entrances and exits and point of care	Room disinfection	Room disinfection

Products / tools not recommended for use during COVID-19		
Sample products / tools	Quaternary Ammonium	Vacuuming may trigger air borne matter

Important to know

- When using cleaning and disinfecting products, staff should ensure that they follow manufacturer's instructions for all products (e.g., concentration, application method and contact time, necessary personal protective equipment, etc.).
- Apply product from controlled containers to a fresh-clean cloth surface every time; avoid pails for dipping / wringing out cloths
- Try to use disposable equipment to clean and disinfect contaminated areas (WHO directive)
- Vacuuming may trigger airborne matter and therefore is not recommended; consider using a carpet sweeper or floor dry mop for carpeted areas in resident care areas
- Additional environmental cleaning is recommended for frequently touched surfaces, including trolleys and other equipment that move around the home, and consideration given to increasing the frequency of cleaning.
- In addition to the below procedures, cleaning staff should ensure they follow standard Environmental Cleaning Best Practices for Infection Prevention and Control (PHO). A sample procedure for room cleaning can be found below, and education materials for cleaning are available in the appendix.

The following products are recommended for cleaning and disinfection during the pandemic, including kill-times (i.e. time that all disinfecting products need to stay wet on the surface to kill bacteria and viruses). Staff should know and follow manufacturers' instructions for all products they use.

Product and use		Kill time / Contact Time
	Brand: *Oxivir TB* Purpose: Disinfection of all areas	1 MIN
	Product: PerCEPT Disinfecting Cleaner Purpose: Disinfection of all areas	5 MIN

The following products are **not recommended** for use in long-term care during pandemics:

Product and use		Kill time / Contact Time
	Quaternary Ammonium	10 MIN
	Lysol Disinfecting Wipes (All Scents)	10 MIN
	Lysol Disinfectant Spray	10 MIN
	Clorox Performance Bleach 1 and 2	10 MIN

Source: *https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2*

#	Steps to implement	Done
P1	Ensure that the following supplies are available for cleaning and disinfecting purposes • All traffic areas / surfaces (both common area and rooms): Oxivir TB • Disinfection of shoes and other items that cannot be wiped: Spray disinfectant • Hand hygiene: Alcohol-based hand rub • Room disinfection: Pulverized spray devices • Substitute for commercially prepared hospital disinfectants (if these are not available): a diluted bleach solution with the concentration of chlorine 5,000 ppm or 0.5% (equivalent to a 1:9 dilution of 5% concentrated liquid bleach). When using bleach, cleaning must precede disinfection	
P2	Ensure that key points of contact are properly equipped with disinfecting supplies: • All entrances, exits, points of care: alcohol-based hand rub (ABHR) • Sinks: Soap, paper towels, tissues for coughing people • Stairs: Disinfecting wipes / disinfection bottle with Oxivir TB and paper towels	
P3	Adjust refilling schedule and processes considering higher use of hand hygiene products	
P4	Develop a schedule for cleaning and disinfection of mobility equipment, personal assistance and support devices (PASD), and lifts	
P5	Ensure that staff is familiar with manufacturer's instructions for all products used and has been trained on the right cleaning / disinfection techniques • Existing staff • New staff (when joining the team)	
P6	Put in place cohorting for cleaning staff, work with HR to develop schedules • Preferred scenario: Dedicated housekeeping team per unit / home area, rest of housekeeping staff is assigned to common areas (i.e. same house cleaning staff is responsible for the same space) • Alternative scenario: Cleaning and disinfecting tasks within the unit / home area are assumed by cohort team members assigned to the unit / home area e.g. PSW; housekeeping staff is assigned to common areas (i.e. same housekeeping staff is responsible for the same space) • Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment).	
P7	Work with HR to ensure staffing for surge capacity in the event of an outbreak	
P8	Ensure supply management plans are in place to allow for surge capacity in the event of an outbreak (products, equipment, etc.)	
P9	Create a schedule for disinfection frequency of all areas of the home	
P10	Create list of all high touch areas in the home, and assign responsible person for each • Keep cleaning staff to one unit / floor as much as possible • High-touch area - common areas: bed rails, door handles, light switches, handrails, chairs, faucets, elevator buttons, trolleys • High-touch areas – resident rooms: overbed tables, call bells, door handles, light switches, chairs, faucets	
P11	Clean and disinfect high-touch areas / surfaces: • High touch surfaces in resident rooms, washrooms, dining areas, public / common areas, staff areas, including equipment that moves around the home	

#	Steps to implement	Done
	• Minimum twice daily frequency of cleaning/disinfection of contact surfaces with 1-min-kill-time e.g. Oxivir TB; ideally more frequent Clean and disinfect other areas / surfaces: • Normal frequency of cleaning/disinfection of contact surfaces with 1-min-kill-time e.g. Oxivir TB; normal hours	
P12	Clean and disinfect dining areas between each sitting	
P13	Clean and disinfect all spaces (e.g. elevators, resident rooms, etc.) • Starting with high-traffic and isolated areas • Use positive pulverized sprayer if possible	
P14	Clean and disinfect each work area prior and after each usage of stations • E.g. medical cart, computer station, phone area, laundry, server, etc.).	
P15	Put in place best practices for cleaning and disinfection of shoes • Spray shoes with disinfectant when exiting isolated environments • Thoroughly wash and sanitize hands after each shoe change	
P16	Put in place best practices for cleaning and disinfection of clothes • Work clothes to be washed at the end of the day	
P17	Work with HR to support employee morale	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Educate housekeeping staff of PPE requirements for cleaning rooms with suspected or confirmed cases (Contact and Droplet precautions)	
O3	Put in place a process to easily identify clean vs dirty equipment and rooms • Prevents staff from reusing equipment that has not been disinfected • Clean/dirty colored labels or elastic bands • Clean/dirty sections marked on the floor	
O4	Clean and disinfect all areas / surfaces: • High touch surfaces in resident rooms, washrooms, dining areas, public / common areas, staff areas, including equipment that moves around the home • Includes but not limited to bed rails, door handles, overbed tables, light switches, call bells, handrails, chairs, faucets, elevator buttons, trolleys • Minimum twice daily frequency of cleaning/disinfection of contact surfaces with 1-min-kill-time e.g. Oxivir TB • Other areas / surfaces: increase frequency where possible	
O5	Clean and disinfect all areas / surfaces within 2 meters of the resident who is suspected / confirmed as soon as possible upon notification and on an ongoing basis	
O6	Clean and disinfect resident room with active COVID-19 • Consider cleaning as the last room of the day • Consider what cleaning can be done by other team members who are having to enter the room for care and support.	

SAMPLE PROCEDURE FOR DAILY CLEANING OF RESIDENT ROOM

#	Steps to implement	Done

1	**Assemble supplies**
	• Gather materials required for cleaning before entering the room.
	• Ensure an adequate supply of clean cloths is available
	• Prepare fresh disinfectant solution according to manufacturer's instructions
	• If COVID positive:
	  ○ Use a fresh bucket and mop head (dust mop and wet mop) for each room, and only for that room
	  ○ After cleaning, apply a disinfectant to all surfaces in the room. Ensure sufficient contact time with the disinfectant	

2	**Before cleaning:** • Follow the manufacturer's instructions for proper dilution and contact time for cleaning and disinfecting solutions. • Check for Additional Precautions signs. Follow precautions as indicated. • Clean hands and put on appropriate PPE when entering room. • Walk through room to determine what needs to be replaced (e.g., toilet paper, paper towels, soap, alcohol-based hand rub, gloves, sharps container) and whether any special materials are required; may be done before or during cleaning process.	

3	**Clean room, working from clean to dirty and high to low areas of the room**
	• Use **fresh cloth**(s) for cleaning each patient/resident bed space:
	  ○ If a bucket is used, do not double-dip cloth(s).
	  ○ Do not shake out cloth(s).
	  ○ Change the cleaning cloth when it is no longer saturated with disinfectant and after cleaning heavily soiled areas such as toilet and bedpan cleaner.
	  ○ If there is more than one resident bed in the room, use fresh cloth(s) for each and complete cleaning in each bed space before moving to the next.
	• Start by **cleaning doors, door handles, push plate** and **touched areas of frame**.
	• Check **walls** for visible soiling and clean if required.
	• Clean **light switches and thermostats**.
	• Clean **wall mounted items** such as hand rub dispenser and glove box holder.
	• Check and remove fingerprints and soil from low level **interior glass partitions, glass door panels, mirrors and windows** with glass cleaner.
	• Check **privacy curtains** for visible soiling and replace if required.
	• Clean **all furnishings and horizontal surfaces** including chairs, windowsill, TV, phone, nightstand, etc. Lift items to clean tables. Pay attention to **high-touch surfaces**.
	• Wipe **equipment on walls** such as top of suction bottle, intercom and blood pressure manometer as well as IV pole.
	• Clean **bedrails**, **bed controls** and **call bell**.
	• Clean **bathroom/shower**
	• Clean **floors**	

4	**Disposal** • Place soiled cloths in designated container for laundering. • Check sharps container and change when ¾ full (do not dust the top of a sharps container).	

#	Steps to implement	Done
	• Remove soiled linen if bag is full. • Place obvious waste in receptacles. • Remove waste	
5	Remove gloves and clean hands with alcohol-based hand rub; if hands are visibly soiled, wash with soap and water. Do NOT leave room wearing gloves or other personal protective equipment.	
6	Replenish supplies as required (e.g., gloves, alcohol-based hand rub, soap, paper towel).	
7	Clean hands with alcohol-based hand rub.	

Source: https://www.publichealthontario.ca/-/media/documents/B/2018/bp-environmental-cleaning.pdf

7.7.2 LAUNDRY

Important to know

- Ensure staff follow Routine Practices
- PPE should be worn when handling (open) soiled linen, including: Plastic aprons, gown, long gloves, eye protection and a mask
- Consider all soiled laundry / clothing as potentially infectious
- Ensure soiled linen / clothing does not contaminate clean linen

#	Steps to implement	Done
P1	Put in place laundry schedule reflecting needs of the community (e.g. cohorting) • Preferred scenario: Laundry can be completed in the unit / home area • Alternative scenario: Laundry can be completed in a dedicated area (e.g. ground floor / basement) • Redeploy housekeeping staff from non-essential environment services (e.g. HVAC services, plumbing unless these services are required due to emergency reasons) to cleaning and laundry • Policies and procedures regarding staffing in Environmental Services departments should allow for surge in linen / clothing use (e.g., have extra-inventory of clean (laundered) linen on-hand, ensure resident clothing is returned quickly).	
P2	Place appropriate containers strategically across the home to collect PPE and arrange schedule to pick up at regular intervals – no cleaning should take place in care areas (e.g. cleaning goggles in sink at nursing station)	
P3	Ensure staff follow PPE cleaning procedures for reusable PPE: • Reusable gowns are can be cleaned with laundry • Reusable face shields and goggles need to be hand washed and dried Detailed instructions can be found in templates	
P4	Suspend environmental non-essential services • E.g. HVAC services, plumbing unless these services are required due to emergency reasons	
P5	Ensure that laundry has necessary supplies (including planning and re-ordering) • Detergent and associated laundry products • Plastic bags and hazardous tags /clearly identifiable bags for hazardous laundry	
P6	Ensure that laundry is done through commercial (temperature controlled) washers, with professionally programmed wash and chemical formulations • Avoid use of domestic laundry equipment / consumer detergents	
P7	Ensure that laundry has designated facilities for hand hygiene	
P8	Store clean linen and clothing in secure areas, without opportunity for cross-contamination. • Avoid linen storage in the resident room	

#	Steps to implement	Done
P9	Organize and complete personal laundry on the respective home areas as 6-laundry days / week where each home area would have a defined day when laundry would be done (incl. personal laundry, all linen, towels). • E.g. Monday: Home area #1 laundry (e.g. Male Special Care) • E.g. Tuesday: Home areas #2 home area laundry (e.g. Female Special Care)	
P10	Ensure that appropriate PPE is worn when handling (open) soiled laundry, linen, and towels: Plastic apron, gown, long gloves, mask, eye protection • Consider all soiled laundry / clothing as potentially infectious • Linen / clothing contaminated with blood or body fluids, should be considered contaminated, regardless of the known resident condition (requires full contact and droplet precautions)	
P11	Ensure that soiled laundry is placed in a plastic bag (i.e. leak-proof bags or containers) and hazardous laundry identified; transport in enclosed leak-proof bags or covered cart)	
P12	Store soiled linen / clothing in separate (labelled) carts, in designated areas in the laundry; clearly identify clean and dirty areas incl path on the floor.	
P13	Wash laundry at 60-90 degrees Celsius (140-195 degrees Fahrenheit) with laundry detergent and dry according to routine procedures.	
P14	Clean and fully disinfect the laundry room between each home area (each laundry day). • Laundry environment and equipment requires daily cleaning and disinfection (including washing machine)	
P15	Work with HR to support employee morale	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	

7.7.3 WASTE MANAGEMENT

Important to know

No special instructions are indicated for COVID-19. Following routine practices such as:

- Ensure staff are follow Routine Practices
- PPE should be worn when handling (open) soiled linen, including: Gowns, Goggles, Gloves/Face Shield
- Consider all soiled laundry / clothing as potentially infectious
- Ensure soiled linen / clothing does not contaminate clean linen

#	Steps to implement	Done
P1	Put in place waste management schedule reflecting needs of the community during the pandemic times • Policies and procedures regarding staffing in Environmental Services departments should allow for surge in waste (e.g., additional PPE).	
P2	Ensure that staff is familiar with waste management handling and controls • Perform Hand Hygiene after handling waste; always use gloves • Watch for anything sticking out of the bag or waste containers • Never dump waste from one receptacle/bag to another • Tie garbage bags before removing from the waste receptacle, never dump waste from one bin to another • Never reach into, or 'push' on the bag, to push the garbage down • Carry the garbage bag away from your body (hold bag by the knot/ties) • If the bag of garbage is heavy and/or there is a chance the bag may break or leak, use a double/bag method	
P3	Ensure that every resident room/bed area has a covered waste receptacle	
P4	Ensure that waste management has necessary supplies (including planning and re-ordering) • E.g. garbage bags	
P5	Work with HR to support employee morale	
P6	Clearly mark bags that contain biohazard (e.g. Red X with Sharpie)	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	

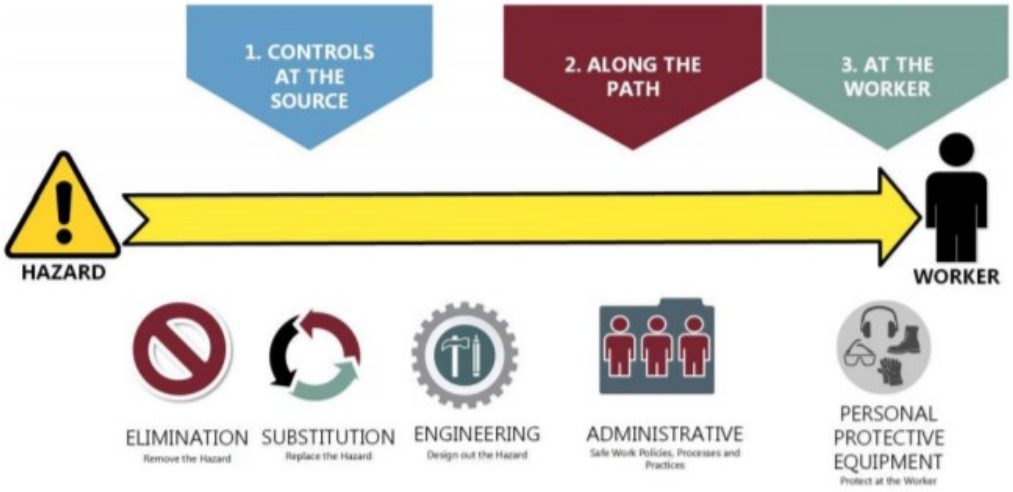
7.8 ADMINISTRATIVE FUNCTIONS

7.8.1 ORGANIZATIONAL RISK ASSESSMENT (ORA)

From the onset of a pandemic, as well as regularly throughout, a risk assessment of the community should be performed. The risk assessment allows leadership to better understand the areas of risk in the home, and adequately plan and respond to them. An ORA is a systematic approach to assessing the efficacy of control measures that are in place to mitigate the transmission of infections in the health care setting.

The ORA is central to any health care organization's preparation and planning to protect HCWs. Organizations have a responsibility to provide education and training to HCWs regarding the organization's ORA, including guidance around the use of PPE.

The home's Administrator should own the ORA, but should fully engage Joint Health and Safety, Occupational Health and Safety and Infection Prevention and Control teams, as appropriate.



Source: https://www.pshsa.ca/resources/infectious-disease-threats-risk-assessment-tool-for-acute-care

The above illustration from PSHSA outlines an approach to eliminate or minimize risks in a healthcare setting. The bottom part of the approach outlines the hierarchy of controls, from preferred control measure, elimination, to least preferred, PPE, based on reliability and effectiveness. Where possible, the home should eliminate; however, where this is not an option, measures should follow the hierarchy with PPE always as last resort or additional measure.

- **Elimination** includes removing the hazard at source (e.g. no visitors)
- **Substitution** involves replacing the hazard at source (e.g. disposable cutlery)
- **Engineering** controls include designing out the hazard (e.g. physical barriers for screening and point of care alcohol-based hand rub)
- **Administrative** controls refer to policies, processes and practices (e.g. screening procedures and appropriate selection and use of PPE)

- **PPE** is to protect the worker, where the risk cannot be eliminated completely at source or along the path

#	Steps to implement	Done
P1	Assess resident risk (**daily**): • Who are the most vulnerable residents (e.g. health conditions, cognitive capacity)? • What impact would isolation have on residents (e.g. depression, violent outbreaks, wandering)? • Speak with nursing staff to understand resident condition • Flag at risk residents and put in place process for frequent checks	
P2	Assess staff shortage risk (**daily**): • Identify critical staffing levels for each role • Assess previous attendance patterns • Evaluate contingency plans for staffing • Account for staff health status and vulnerability to disease • Hire as appropriate • Evaluate sick leave policies	
P3	Assess supplies risk (**daily**): • Understand minimum supplies levels for all critical supplies (PPE, medication, oxygen, food) • Speak with suppliers to understand readiness • Identify various alternate suppliers • Put in place to maintain daily count of critical supplies • Put in place order process for critical supplies to maintain minimum levels	
P4	Create plan to manage and minimize each key risk identified	
P5	Revise Continuity of Operations plan and update as required. Plan should include: • redeployment of human resources, equipment or space to protect critical services • minimum thresholds for staffing by function Work with HR on staffing piece.	

7.8.2 ADMISSIONS, RE-ADMISSIONS AND DISCHARGE

#	Steps to implement	Done
P1	Admissions from hospitals are not permitted. Re-admissions from **hospitals** should only happen if: • The home is not in an outbreak • The resident has been tested and results were negative • Is **transferred within 24 hours** of receiving the results • The resident will self-isolate for 14 days from arrival and the home has plans in place to support isolation (i.e. contact and droplet precautions, PPE, in-room dining, etc.) – see Suspected Case • The resident is screened twice daily	
P2	Admissions and re-admissions from the **community** should only happen if: • The home is not in an outbreak • Is tested within 24 hours before admission • The resident will self-isolate for 14 days from arrival and the home has plans in place to support isolation (i.e. contact and droplet precautions, PPE, in-room dining, etc.) – see Suspected Case • The resident is screened twice daily	
P3	If there are an increasing number of cases in the region, operators at their own discretion should assess whether resident admissions from the community could be delayed / deferred	
P4	Family members should not enter the home when a new resident is admitted. Personal belongings should be disinfected before being brought into the home, and ideally, held outside for 3 days before move-in.	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	In an outbreak, cease all admissions / re-admissions	
O3	Should a family decide to take the resident out of the home during an outbreak, the resident may not come back until the outbreak is over	

7.8.3 BUDGETING AND FINANCE

A pandemic poses unique financial challenges on long-term care that include but are not limited to:

- Increased costs (e.g. growing PPE costs, additional staff and supply costs)
- Changes in occupancy (e.g. due to home lock downs, changes in admissions, changed public perception of LTC homes, re-use of available rooms for isolation purposes, increase in mortality rates, etc.)
- More difficult financial forecasting / planning

#	Steps to implement	Done
P1	Estimate, monitor and validate cost increases due to pandemic • Increased infection control (e.g. additional PPE and disinfection materials) • Increase in staff numbers to care to provide pandemic-tailored care (e.g. isolated residents, wandering residents) • Increase in prices for essential supplies • Other costs (e.g. staff training, screening, substitution, vaccination, etc.)	
P2	Work with management to identify and manage immediate expenses and investments required, reallocate capital as appropriate • Consider delaying non-essential renovations and expenses • Help order management designate(s) negotiate payment terms and pricing • Understand all available credit facilities • Evaluate available government support	
P3	Develop and maintain forecasts and budgets for prudent financial management • Collect statistics to inform budget development / forecasting (e.g. occupancy changes) • Compile result data on monthly, quarterly, annual basis • Incorporate contingency for potential follow-up outbreaks • Request budget changes	
P4	Manage cash flow including identification and resolution of potential challenges • Manage accounts receivable and payable • Deal with payment issues (e.g. delays, vendor bankruptcies)	
P5	Manage financial aspects of relationships with new vendors including but not limited to • Setup new vendors in the financial system • Review and validate invoicing / bills • Execute vendor payments through a variety of possible avenues (e.g. direct transfer, credit card, etc.)	
P6	Support applications for government support programs and track receipt of funds	
P7	Participate in emergency discussions with municipal and provincial authorities in relation to financial topics (e.g. explain estimated expenses)	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Rework financial planning, budgets and cost estimations in case of an outbreak • Additional impacts on occupancy • Changes in staffing needs • Other cost impacts	

7.8.4 TECHNOLOGY

It is important to ensure that technology provides necessary support and can be relied upon throughout the pandemic. Here are key topics to consider:

Topic	Details
Technology supporting remote work	The following technology components are set up and tested for remote work: • Hardware (laptops) • Virtual Private Network (VPN) • Teleconferencing tools • Remote access to shared data • Remote access to key applications (e.g. EHR, Surge learning, Payroll, Billing) • Consider additional secure mobile network devices (e.g. encrypted Rogers stick)
IT supplier / support	If IT services are provided by an external provider, it is important to make sure that following topics are addressed: • Ability to address most technology challenges remotely • Remote backup and disaster recovery • 24/7 IT help desk for staff • Ability to provide support on-site in case of emergency e.g. WiFi / network is down • Ensure you consider vendors and support for key systems as well (e.g. PCC, Surge learning)
WIFI network	Many residents may become heavily dependent on internet connection as it is used for communication with loved ones (audio and video), watching movies, browsing, etc. It is recommended to review the current contract / agreement with internet provider and ensure that there is enough bandwidth to deal with a surge of internet usage.
Security	Security risk is higher as a number of staff members work remotely. Several data breaches have occurred since the beginning of the recent pandemic. It is important to educate staff on secure ways to handle data especially containing personal data and how to be aware of potential scams and fraud schemes. Ensure only staff who need access to resident data have access to it.

7.9 RECREATION

The Recreation team plays an essential role in ensuring resident wellbeing and morale throughout the pandemic. While most typical activities are suspended, Recreation staff can develop activities for small groups, one-on-one, and in room. Recreation staff should clear activities with Nursing and Joint Health and Safety to ensure they comply with the latest pandemic procedures and specific resident needs.

Resources for recreation staff:

- BSO's guide (designed for individuals living with dementia but applicable more broadly)
- Pioneer Network's Resource library
- Activity Connection COVID-19 Care package
- Health Innovation Network's Activities for Older Adults during COVID-19
- Age-u-Cate
- The below table includes ideas from other homes

In room activities	Hallway activities	Daily small gestures
• Crosswords, word search, colouring books, trivia sheets • Knitting, puzzles, painting, etc.; provide supplies • Movies, TV, music, audiobooks (can purchase portable devices to be disinfected between uses) • Create mini activity kits with a combination of the above • Hand out devotional reading / prayer for spiritual residents • Consider online mass via TV or tablets during pandemic • Painting rocks to leave around community	• Bingo • Adapted board games (e.g. Yahtzee with each their own dice) • Word games / trivia • Sing-a-longs • Live music by team member • Hallway meditation • Exercises	• Leave printed quote in room • Daily greeting / prayer over PA • Resident spa (bubbles and battery-operated candles in tub) • Short video from family • Bubbles in the garden • Flower on plate • Staff crazy hair day • Joke of the day

#	Steps to implement	Done
P1	Review all existing activities and modify to ensure physical distancing. Only small group activities where physical distancing can be maintained should take place.	
P2	Prepare activities for residents in their rooms or practicing physical distancing. This can include developing an "in room" calendar for recreation. Examples include: • Hallway / doorway bingo, fitness classes, etc. • Individual activities such as puzzles, art / painting in room, coloring, crosswords, etc.	

#	Steps to implement	Done
	• Postcard / letter writing to family, friends or other residents • Play soft noise music • Small group outings to garden areas (with physical distancing) • Install bird feeders to provide outside visuals • One on one activities with recreation staff • Encourage families to provide gifts such as plants, books, smart devices for calls, etc. For additional individual activities, see resources above. Activities should be tailored to individuals' preference while maintaining safety of staff and residents a priority.	
P3	Ensure all materials used in recreation are adequately sanitized.	
P4	Schedule virtual calls with families on a regular basis.	
P5	Organize outside/window visits from families. Other outside events that allow residents to remain in isolation can include outside/window concerts,	
P6	If possible, capture photos / videos of residents to share with family Note: Prior consent from resident and family may be required, and staff should not use their personal device to record images of residents	
P7	Work with HR to support staff morale	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	When there is a suspect or known case, **cease all group activities**, only in-room individual recreation	

7.10 PHARMACY AND OXYGEN THERAPY

Pharmacy and Oxygen suppliers are critical suppliers in a pandemic and should be closely informed of any changes in the home / resident(s) and any additional support required. Given that both Pharmacy and Oxygen providers are external suppliers (i.e. people or supplies can carry infection), it is important to put in place proper measures to protect residents and staff.

#	Steps to implement	Done
P1	Notify Pharmacy of any signs and symptoms / positive case	
P2	Prepare symptom management list and order	
P3	Align with DOC/DON and nursing team on additional Pharmacy tasks as related to outbreak	
P4	If possible, work with providers to enable waiting time for medications (e.g. ordering in advance)	
P5	Ensure that government medication supply has enough supplies to cover 3 days of unexpected changes to treat all COVID-19 symptoms (e.g. Tylenol, etc.)	
P6	Work with nursing team to review residents' medication schedule to minimize the number of times staff need to enter the room	
P7	Ensure that there is one medication cart per unit / home area • If there are not enough medical carts, share one cart per floor with full disinfection before entering a unit / home area	
P8	Disinfect medication cart between each medication delivery / use	
P9	Review Oxygen supplier(s) and consider / identify alternative Oxygen suppliers	
P10	Ensure sufficient Oxygen supplies in the home	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	

7.11 EDUCATION

#	Steps to implement	Done
P1	Include **signage** across home to remind staff and residents of best practice for: • Infection control and prevention • PPE use • Hand hygiene (see templates for Handwash and Handrub) • Disease symptoms • Steps to take if infection is suspected	
P2	Train **staff** on / provide refresher training on: • Infection control and prevention • PPE use and proper donning / doffing procedures • Appropriate PPE conservation measures • What is and isn't and Aerosol Generating Medical Procedure (AGMP) • Hand hygiene and hand disinfection • Universal masking • Physical distancing • Viral agent symptoms • What to do if they suspect they have been infected • Post-mortem care during pandemic • How to do line listing PHO offers online IPAC training that can be used to provide refreshers on IPAC practices	
P3	Educate **residents** on: • Physical distancing • Hand hygiene • Disease symptoms	
P4	Educate **residents and visitors** on: • Physical distancing • Hand hygiene • PPE use, donning and doffing if applicable • Other rules and guidance in place • Viral agent symptoms and what to do if they suspect they have been infected	
P5	**Environmental Services staff** have received education and training on the correct way to clean (e.g., use the correct dilution, correct contact time, clean from clean to contaminated and from top to bottom, do not double dip)	
P6	Prepare signage for immediate use when a resident needs to be placed on **Droplet / Contact precautions and in isolation**	
P7	Implement processes for ensuring **new information is shared between shifts** (e.g. huddles for each shift, written and verbal updates, education delegates for each shift and cohort, etc.)	
P8	Provide frequent **reminders to staff on health and safety**, mental health and wellness resources available to them	
P9	Consider **alternate means on educating staff** given large amount of new information (e.g. SMS for critical information, virtual training, flashcards)	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	

#	Steps to implement	Done
O2	Ensure **staff is informed** of the latest information regarding the disease, how to manage it, and the impact on how they do their work	

7.12 SUPPLY MANAGEMENT

Important to know

Preparing for and responding to an outbreak requires critical supplies outlined in the below section.

- The home should determine its par supply (daily usage) and use a risk factor to calculate minimum quantities to have on hand; consider increased usage when calculating this (e.g. more frequent cleaning)
- In addition, supplies for which demand will surge once there are positive cases should be identified and minimum quantities account for this (e.g. disposable cutlery)
- As pandemics often create supply shortages in critical supplies such as PPE, homes should communicate with suppliers frequently to understand the situation, and potentially order further ahead of time
- Alternate suppliers for critical supplies should be identified
- Authorities may require reporting of inventory on hand for critical supplies (PPE, ABHR, etc.) – ensure processes are in place

7.12.1 PPE SUPPLY

Category	Supplies	Done
PPE	Surgical Masks	
	N95 respirators	
	Gloves (all sizes)	
	Gowns – reusable and disposable (all sizes)	
	Face shields – reusable and disposable	
	Goggles – reusable and disposable	

7.12.2 DINING SUPPLY

Category	Supplies	Done
In-room dining supplies	Individual tables	
	Paper / disposable plates, cups and cutlery	
	Trays	
	Additional carts to allow use of separate equipment for each floor / unit	
	Additional containers	
Food supplies	Pandemic menu	
	Thickeners	
	Supplements	

7.12.3 NURSING / CARE SUPPLY

Category	Supplies	Done
Supplies and Equipment	Government stock	
	Thermometers	
	Thermometer tip covers (account for higher usage)	
	Bloodwork equipment	
	Wound care supplies	
	Tube feeding equipment	
	Oxygen tanks (if applicable)	
	Additional carts to allow use of separate equipment for each floor / unit and positive / negative residents	
Pharmacy	Symptom management medication	
Emergency Supplies	Swab kits / Testing kits (if available)	
	Bracelets / magnets / lanyards to allow for identification of positive residents prone to wandering	
In-room Supplies	Bedside commodes (if required to avoid sharing bathrooms or for isolation plans)	
	Personal basin for each resident (for bedside bathing)	
	Helical basin for each resident	
	Plastic bins for personal belongings if resident needs to be relocated / distanced	

7.12.4 ENVIRONMENTAL SUPPLY

Category	Supplies	Done
Cleaning / disinfectant products	Oxivir TB	
	Oxivir wipes	
	PerCEPT disinfectant cleaner	
	Other cleaning / disinfecting agent used in the home	
Laundry products	Laundry chemicals	
	Laundry bags	
Hand Hygiene supplies	Hand soap	
	Alcohol based hand rub (ABHR)	
	ABHR dispensers (extra may be required to put in all recommended locations)	
	Paper towels	
	Paper towel dispensers (extra may be required to put in all recommended locations)	
	Batteries if dispensers are battery powered	
Linen	Extra bed linen	
	Extra towels	
Supplies and Equipment	Positive particle disinfectant sprayers	
	No touch receptacles for PPE	
	PPE plastic carts	
	Plastic bags – clear, biohazard	

Category	Supplies	Done
	Walk behind floor scrubber (recommended over mops / vacuums)	
	Additional cleaning supplies to account for higher consumption and use of separate equipment for each floor / unit (e.g. cloths, wipes, etc.)	
	Additional carts to allow use of separate equipment for each floor / unit (for cleaning staff, nursing staff, laundry staff, rec staff, etc.)	
	Physical barriers (e.g. plastic shower curtains, plexiglass, etc.)	

7.13 SPECIALISTS AND OTHER FUNCTIONS

Important to know

Homes should follow official guidance regarding essential providers and evaluate resident needs to define whether a service is required based on clinical judgement. Services should be defined as Essential and Non-essential based on the below definitions:

- ***Essential Services:*** Meet basic needs of residents in their daily life and are required for residents to survive; these services should continue throughout the pandemic
- ***Non-essential Services:*** Have a significant impact on residents' quality of life but are not strictly required for residents to survive; these services should be stopped in outbreak and while essential visitor restrictions apply

As part of the ongoing evolution of the pandemic, each service should be evaluated to determine the risk continuing or discontinuing each poses, considering local outbreak conditions, and whether it can be adjusted to reduce risk of infection in the community. Per directive updates on May 26, 2020, Health Care Providers must consider which services should continue to be provided remotely and which services can safely resume in-person with appropriate hazard controls and sufficient PPE.

Potential approaches once non-essential services are allowed include:

- Suspending the service until after the pandemic (e.g. animal therapy)
- Offering the service remotely (e.g. specialists, dietitian)
- Reducing frequency (e.g. physiotherapy)
- Adapting the activity (e.g. physically distant church groups, window concerts by outside entertainers, in-room music therapy, care staff to perform basic hairdressing services)

Note: Some of these services may be considered non-essential visitors and therefore should not be allowed to enter the home until updated guidance is provided

As an example, hairdressing services are usually considered non-essential and suspended early in the pandemic, but considering the potential longer-term duration, may be reintroduced as an aspect of basic care. **Homes should always follow Public Health directive when considering which services to reintroduce**. Once authorities provide guidance non-essential services can be restarted, potential measures may include reintroducing hairdressing services when not in outbreak, with the following precautions:

- Cohort residents to receive services (e.g. week 1 home area 1, week 2 home area 2, etc.)
- No services provided while a resident is suspected or positive
- One resident at a time in hair salon
- Disinfection of salon and tools between each resident
- Resident to wear mask if tolerated
- Hairdresser to wear mask, face shield, gown and gloves and change between each resident
- No hair dryers to avoid spreading particles, especially if resident is unmasked

- Caution with shared products (can use hotel sized bottles for each resident or disinfect bottles between each use – products that cannot be applied safely (e.g. gels that require dipping hand in jar) should not be used)

#	Steps to implement	Done
P1	Follow Authorities / Administrator directive as to whether service should continue/restart or not – all non-essential services should be stopped until further notice in accordance with non-essential visitor restrictions	
P2	Consider redeploying staff in additional services across areas of the home where additional staff is needed (e.g. housekeeping, one on one recreation)	
P3	Staff across all additional functions and services should follow proper PPE, hand hygiene and physical distancing requirements when in the home	
P4	If a service is deemed essential, notify provider and inform them of precautions in place. Consider using a dedicated room close to the entrance for service provider visit to minimize risk of infection within the facility. This room should be cleaned and disinfected after each use.	
P5	Any specialist coming into the home should be screened and use full PPE, and visit a minimum number of residents	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	All non-essential services are stopped (if they had been reintroduced) unless otherwise indicated by Administrator / Infection Prevention and Control officer	
O3	For services provided to positive residents, evaluate resident need against option of delaying treatment while resident remains positive.	

7.14 COMMUNITY PROGRAMS

Community programs should be evaluated on an ongoing basis to determine whether or not they are essential in the context of a pandemic, and if they are deemed essential, what changes would be required to the program to ensure service delivery while protecting staff, volunteers and beneficiaries of the program. In addition, any new guidance from MOHLTC or Public Health should be taken into account.

It may be helpful to monitor response from peer organizations to assess which programs are suspended, maintained (and modified), or restarted.

Community programs assessment	
Community Need	• Does the program meet an **essential need** in the community? • What would be the **impact of suspending** this program for a day / a month / 6 months?
Alternatives	• Are there existing **alternatives** to fulfill this need? • Are they as **safe**? • Do they have the **same cost** to beneficiaries / the community? • If there are no current alternatives, are there **partners** that could help deliver the service (e.g. government, other community organizations, business, etc.)?
Risks	• What are the **risks** of continuing delivering this program? • Does the program require close contact or interaction between staff or residents and the general public? • Is anything coming into / from the facility that could potentially be infected? • Does the program involve **physical touchpoints** in the community?
Changes	• What **changes** are required to minimize those risks while meeting the needs of beneficiaries? • Can the program be changed to **meet the need in a similar way** (e.g. frozen meals for meals on wheels, remote program, lower frequency, etc.)? • Can the program be altered to promote **physical distancing / contactless** service delivery?

7.14.1 MEALS ON WHEELS

#	Steps to implement	Done
P1	Contact participants of the program to inform them of changes in procedures and confirm program continuity	
P2	Encourage shift to frozen meals in bundled (i.e. 7 days per package) deliveries where possible	
	Create back up plan should there be no frozen or hot meals available for delivery (e.g. other facility, healthcare institution, municipal services, etc.)	
P3	Ensure volunteer contact information is up to date and add to appropriate notification lists	
P4	Volunteers involved in the program should be screened before meal deliveries	
P5	Volunteers should: • Self-monitor for any symptoms • Wear a mask at all times • Not participate in the program if they may have been in contact with someone who was infected • Not enter the facility, nor come in contact with any staff or residents • Disinfect vehicles before and after deliveries • Perform frequent hand hygiene • Maintain physical distancing from staff, meal recipients and other volunteers Wait after knocking 2m away from the door to ensure meals are received	
P6	If volunteers need to work in groups, put cohort practices in place (e.g. same 2 volunteers always working together) • Inform volunteers of physical distancing, hand hygiene, PPE use and screening best practices • If sharing a vehicle, the passenger should sit in the right-hand side of the backseat	
P7	Provide hand sanitizer, masks and disinfecting wipes to all volunteers	
P8	Dining staff should avoid any contact with volunteers and deliver meals bags in a defined location outside the facility	
P9	Disinfect delivery bags upon return to the facility. Ensure the bags are in good condition (e.g. no rips) to ensure proper disinfection – discontinue use if ripped / damaged	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Follow direction from local PHU and other authorities regarding program continuity (e.g. decision may be made to leverage other facility to deliver program during outbreak, set up temporary external kitchen outside with dedicated staff, etc.)	

7.14.2 ADULT DAY AWAY PROGRAM

Adult Day Away programs have been stopped as part of initial guidance by authorities. As the pandemic extends into several months, such programs may potentially be allowed to be reintroduced under certain conditions. Homes should **always follow Public Health guidance as to whether or not to reintroduce programs**. The below outlines initial recommendations based on current knowledge and best practice in other areas, and does not reflect official guidance specific to Adult Day Away programs (which has not been issued to date). As new information and guidance becomes available, this guidance should be updated and re-evaluated prior to reintroducing programs.

#	Steps to implement	Done
P1	Shutdown program while restrictions on essential services are in place or there is significant spread in the community	
P2	Follow Public Health / Government guidance on whether Adult Day Away programs can be restarted (e.g. essential visitor restrictions, etc.)	
P3	Contact Adult Day Away Program participants and caregivers regularly to check in and provide assistance remotely (e.g. ideas for activities while in isolation) • Consider providing remote programming based on participants' potential engagement levels	
P4	Determine space in which program can be held, following the below criteria: • Physical distancing between all participants at all times • No contact with residents or non-program staff (consider access to bathrooms, break rooms, entrance) • Separate entrance for staff and participants • Depending on number and profile of participants, consider holding outdoors programming	
P5	Evaluate maximum number of program participants based on space available	
P6	Consider whether transportation can safely be provided. • If transportation is to be provided, also consider maximum number of participants that can be safely transported • If transportation cannot be provided, ensure participants have access to transport	
P7	Define number of staff required based on participants and programming; staff should be dedicated to the program • If close contact / care is to be provided to program participants, one program staff should only require close contact with one participant to avoid spread between participants	
P8	Consider staffing contingency in case program staff become symptomatic	
P9	Inform facilities staff: • All staff to be advised not to enter that part of the facility and prevent residents from entering • Dining staff advised if meals need to be provided • Cleaning staff advised of enhanced cleaning procedures for that section of home	
P10	Ensure sufficient capacity to support the program across areas required	

#	Steps to implement	Done
P11	Depending on number of participants, consider dedicating cleaning staff to program to ensure frequent cleaning of high touch surfaces and especially disinfection of shared restrooms after each use	
P12	Adapt programming and activities to support positive participant experience while maintaining safety of staff and participants	
P13	Put signage and markers across program area (hand hygiene, physical distancing, etc.)	
P14	Once it has been established how the program can be supported, plan for gradual start (e.g. week 1: 2-3 participants per day, week 2: 4-6 participants per day)	
P15	Put cohort practices in place for program participants (e.g. week 1 day 1 participants 1-7, week 2 day 1 participants 8-15)	
P16	Implement daily process daily to gather feedback from staff and participants in the program especially in early days to make adjustments (e.g. is it safe to increase number of participants, are participants maintaining physical distancing, etc.)	
P17	Contact participants of the program to inform them of changes in procedures, precautions being taken and confirm program continuity; evaluate participants' desire to partake in the program at this stage (i.e. consider risk for them, media attention, etc.)	
P18	Staff and participants involved in the program should be screened before entering and prior to leaving	
P19	Inform staff and participants of physical distancing, hand hygiene, PPE use and screening best practices	
P20	Provide hand sanitizer, masks and disinfecting wipes to all participants and staff of the program	
P21	Inform participants (and/or their family) they should: • Self-monitor for any symptoms • Not participate in the program if they may have been in contact with someone who was infected • To contact the facility if they (or someone they have been in contact with) is presenting symptoms • Perform frequent hand hygiene • Maintain physical distancing from staff, participants and other facilities staff and residents	
P22	Dining staff should avoid any contact with participants and program staff and deliver meals in a defined location without coming in contact with those in the program	
P23	Clean and disinfect facilities after each day at a minimum	
O1	Continue with all activities listed in the prevention section unless otherwise indicated below	
O2	Suspend program or follow direction from local PHU and other authorities regarding program continuity (e.g. decision may be made to leverage other facility to deliver program during outbreak, set up temporary external kitchen outside with dedicated staff, etc.)	

8 LEADERSHIP IN A PANDEMIC

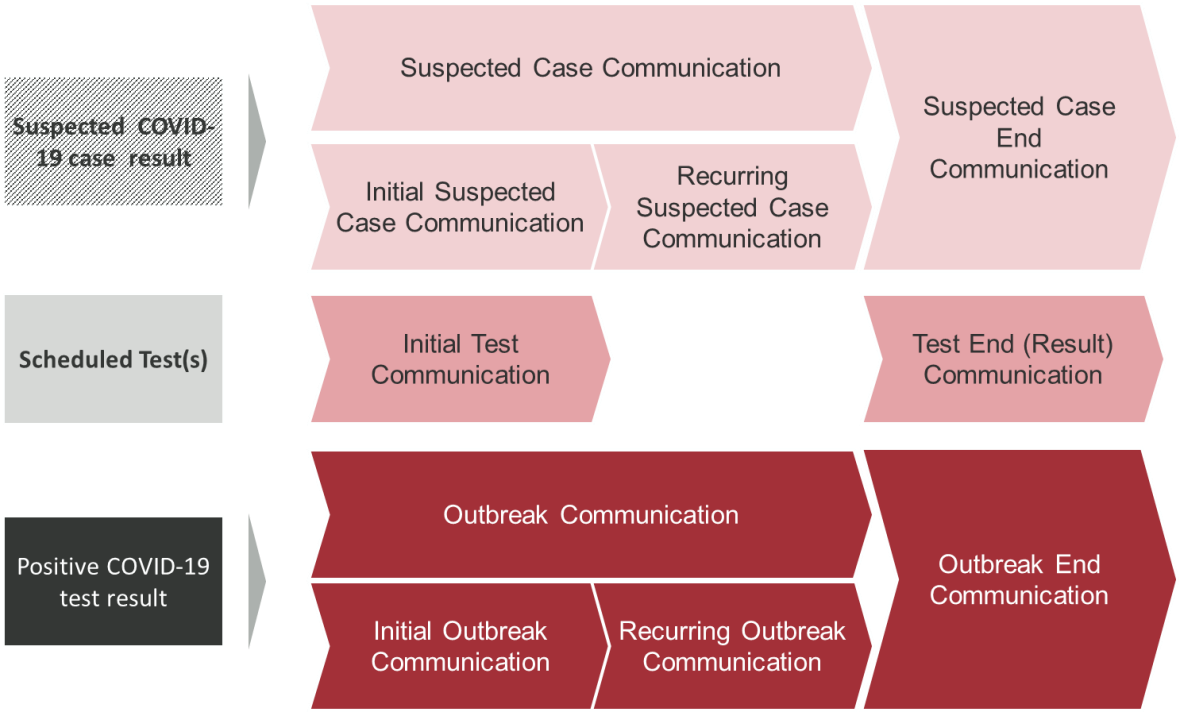
8.1 COMMUNICATION

Communication is one of the most important elements of pandemic management. There are three main instances where communication is critical:

- Suspected Case
- Scheduled Testing
- Outbreak

Communication should encompass multiple stakeholders (e.g. internal, external, authorities) and the various frequencies and channels to communicate with each of them. Please note that some stakeholders must be notified immediately in certain cases, while others should be notified within a specified timeframe.

The below outlines the most essential elements of communication. Additional communication is very welcome and desired for many stakeholders (e.g. families).



Below is a detailed breakdown of communication required for each scenario. Please note that this plan represents general guidance and must be adjusted based on community needs. The full-size overview can be found in the Appendix.

		Prevention & Preparedness	Suspected Case				Test		Outbreak		
			Initial		Ongoing	End	Initial	End	Initial	Ongoing	End
Category	Who has to be informed	Ongoing	Immediate	Within 24 hours					Immediate		
Internal	Home Management	Yes (weekly)[1]	Yes		Yes (daily, tracking increase in cases)	Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	Outbreak Management Team (OMT)	Yes (weekly)[1]	Yes		Yes (daily)	Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	Infection Control Lead	Yes (weekly)[1]	Yes		Yes (daily)	Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	Joint Health & Safety Committee	Yes (as required)	Yes			Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	All affected residents and families	Yes (weekly)[2]	Yes (by home area)		Yes (daily)	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	All non-affected residents and families	Yes (weekly / as required)		At discretion of management	Yes (weekly)	Yes	Yes	Yes	Yes	Yes (2-3 times a week)[5]	Yes
	All home employees	Yes (weekly / as required)[3]	Yes		Yes (daily)	Yes	Yes	Yes	Yes	Yes (q shift)	Yes
	Regional Leaders / HQ / Board (if applicable)	Yes (weekly reports, template)	Yes		Yes (weekly / bi-weekly[5])	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	Home Medical Director / Physician		Yes		Yes (weekly)	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	Home Line Listing: Resident		Yes		Yes (weekly)	Yes	Yes	Yes	Yes	Yes (q shift)	Yes
	Home Line Listing: Employee		Yes			Yes	Yes	Yes	Yes	Yes (q shift)	Yes
	Signage (Room / Unit / Building)	Yes (selective[4])							Yes (Put Outbreak Signage in place)		Yes (Removal of Outbreak Signage)
External	Pharmacy		Yes			Yes			Yes		Yes
	Laboratory			Yes		Yes			Yes		Yes
	Other suppliers / contractors			Yes (change delivery mode)		Yes			Yes		Yes
	Agency support (if applicable)						(depends on survey)	(depends on survey)	Yes		Yes
	Volunteers						(depends on survey)	(depends on survey)	Yes		Yes
Autho-rities	Local Public Health	Yes (as required e.g. for eventual questions)	Yes (request swabs)		Yes (every second day / weekly)[5]	Yes	Yes	Yes	Yes (PHU makes the announcement)	Yes (daily)	Yes
	Municipal / City Authorities		Yes (tbd)		Yes (twice a week)[7]	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	Director for the LTC Ministry / MOH				Yes (weekly)[8]				Yes		Yes
	Hospital Emergency Department / Paramedics						Yes	Yes	For all transfers including prior ones		Yes
	LHIN						Yes	Yes	Yes		Yes
	Union(s) representatives		Yes			Yes	Yes	Yes	Yes		Yes
	Ministry of Labour (if employee(s) affected)		Yes			Yes			Yes		Yes

1 - Weekly meeting with all departments, e.g. budget, EHR minutes, Whats - TELUS app
2 - Updates e.g. what we do regarding PPE, cohorting, window visits, etc
3 - Depends on tech available for employees, e.g. via Whatsup - push communication
4 - Selective e.g. temperature, distancing, travellers as applicable
5 - Depends on available resources for communication
6 - The more communication, the better
7 - Suspected case communications as operational meetings with city 2x / week - need to notify in cases of resident isolation or staff off
8 - Weekly communications with MOH inspector to advise on status

The following section summarizes the key communication activities that must happen once a positive case is identified in the home (resident or staff).

8.1.1 STAFF

#	Steps to implement	Done
1	Notify Home Management	
2	Notify Outbreak Management Team (OMT)	
3	Notify Infection Control Lead(s)	
4	Notify all employees • Include education about the outbreak (including the latest stats) • Reinforce rules that are in place during the outbreak (e.g. cohorting, building access, screening, etc.) • Share with reception employees the protocols for self or active screening of all entering the home • Advise on signs/symptoms of the infection and management protocols. • Leverage staff meetings at the start of each shift to update all personnel on outbreak status • Ensure that both part-time and full-time are informed (including guidance for part-time staff)	
5	Notify company Regional Leaders / HQ / Board (if applicable)	
6	Notify Home Medical Director / Physician / Nurse Practitioner • Alert about outbreak and the signs and symptoms of the infection • Provide all necessary directions and protocols from the Infection Prevention and Control Officer-Outbreak Management Team.	
7	Notify Laboratory • Share additional responsibilities for outbreak	
8	Notify Pharmacy • Share additional responsibilities for outbreak	
9	Notify other suppliers / contractors	
10	Notify agency support (if applicable)	
11	Notify Volunteers • Include education about the outbreak (including the latest stats) • Reinforce rules that are in place during the outbreak (e.g. cohorting, etc.) • Reinforce the importance of practicing proper infection control measures both at the facility and at their own residences. • Reinforce the importance of reporting symptoms and if necessary, absenting themselves from any volunteer work in the home if they have any symptoms. • Adhere to the restriction on normal volunteer activities, on the closure of the home to the public and the restrictions, if any, on residents leaving the home.	

8.1.2 RESIDENT AND FAMILY

#	Steps to implement	Done
1	Notify all affected residents and their families / visitors • Whenever possible, it is best to connect with all families via a phone call, which helps to maintain and build trust • Learning about the outbreak via another source such as local news can lead to frustration, anger and mistrust • Consider how leaders, team members and others who are in isolation can support this task • Share education about the outbreak (including the latest stats) / information sheets • Highlight the measures in place to protect the residents including a way to contact the home / get more info • Reinforce rules that are in place during the outbreak (e.g. no visitor policy, etc.)	
2	Notify all non-affected residents and their families / visitors • See #1 above	
3	Provide regular outbreak communication to residents and their families • Include education about the outbreak (including the latest stats) / information sheets • Highlight the measures in place to protect the residents including a way to contact the home / get more info • Reinforce rules that are in place during the outbreak (e.g. no visitor policy, etc.)	

8.1.3 AUTHORITIES

#	Steps to implement	Done
1	Notify Local Public Health • Obtain an outbreak code/number from the public health authority if the outbreak is confirmed as applicable • Submit an initial outbreak report	
2	Notify City of Cornwall	
3	Notify Director for the Ministry of LTC	
4	Notify Hospital Emergency Department / paramedics • Completed by Public Health • Notify the hospitals who have admitted residents of the existence of an infectious disease outbreak and if the home has been closed to re-admission.	
5	Notify LHIN • Completed by Director of Care • Inform about onset of outbreak -admission of new residents	
6	Notify Joint Health and Safety Committee	
7	Notify Ministry of Labour (if employee(s) are affected)	
8	Notify Transfer Authorization Centre • Completed by Public Health	
9	Provide regular outbreak status update for Local Public Health	

8.1.4 SUPPLIERS

#	Steps to implement	Done
1	Notify critical suppliers (e.g. PPE, nursing supplies) and assess ability to meet volume increase	
2	Notify all other suppliers and reconfirm protocols (e.g. screening, no entry in the facility, etc.)	
3	Post signage at designated reception area so all delivery drivers are aware home is in outbreak	

8.1.5 SIGNAGE

#	Steps to implement	Done
1	Put up signage: **room** • Signage on the door indicating status • Droplet and Contact Precautions • Airborne precautions – only for AGMP	
2	Put up signage: **unit / home area** • Entrance to affected unit / home area - outbreak signage as per Public Health	
3	Put up signage: **building** • Outbreak signage, including home entrance (as per Public Health)	

8.2 STAFF ENABLEMENT

In order to perform their duties properly during difficult pandemic times and outbreak in particular, staff members need to be empowered by leadership. Staff enablement encompasses both knowledge, training and communication. Below are few actionable ideas to improve staff enablement and skills during a pandemic.

Set up a model COVID-19 room	This will help staff to visualize how best practices will be incorporated into your specific facility setting, and how the role of staff might change. Include all signage and materials needed to set up Transmission-based Precautions. Give hands-on training on appropriate use of PPE, including practice putting on (donning) and taking off (doffing) PPE.
Day-in-a-life of care for a COVID-19-positive resident	Consider routine COVID-19 scenarios like resident care, room cleaning, waste removal, dietary needs, and transport of residents for external medical care, like dialysis. Also consider more rare scenarios that will require a planned approach and clear staff expectations to care for COVID-19 residents (e.g., CPR).
Identify essential activities and ensure cohorting of cases	It is important to cohort / limit the number of staff that come in contact with COVID-19-positive residents and the amount of PPE that is used. In general, only essential staff should enter the room of residents with COVID-19. Work together to ensure that essential tasks are completed with the least risk to staff. For example, consider how meals will be delivered, waste removed, and high-touch surfaces cleaned while exposing the fewest staff possible.
Review the chain of command	Ensure clear direction is provided for staff as to who they should go to with concerns or requests, and to report material shortages or changes in medical condition
Set up a Town Hall with your staff	Be clear and honest, and listen to concerns. Downplaying COVID-19 cases and deaths would be disingenuous, could undermine your credibility, and could be perceived as your “not hearing” or being out of touch with staff concerns. There is undeniable risk when staff are in direct contact with a resident that has COVID-19. Focus on ways to best protect the staff during this interaction, with education on protective measures being a critical element. Also use this time to highlight areas (e.g., social distancing, hand hygiene) that need work.
Walk the floors weekly to boost morale and show support	Leaders, including the Administrator and Medical Director, can be present, walk the floors (under consideration of cohorting rules / use of PPE as needed), recognize challenges, and acknowledge the hard work of staff. If staff are expected to work on-site when residents are ill with COVID-19, leadership can show solidarity by doing the same.
Model desired behaviors from the top down	Have a head nurse / nurse in charge demonstrate how to safely and effectively don and doff PPE, answer questions, and provide hands-on training. That same leader should provide weekly supportive oversight to ensure PPE is being used correctly.
Establish a buddy system	The buddy system can be used to ensure PPE and hand hygiene are used correctly and to lend an ear during these difficult times. Physical safety as well as mental health and well-being are essential at this time.

8.3 STAFF RECOGNITION AND ENGAGEMENT

The circumstances surrounding a pandemic are extraordinary and employees can expect to work longer hours and under highly stressful conditions, e.g. working with or near positive residents. Frequent and sincere recognition should be a key part of every leader's role in a pandemic. In addition, leaders can help reduce staff anxiety and stress through meaningful gestures.

It is important to note however that staff recognition activities cannot in any circumstance replace or come at the expense of employee safety. **Always prioritize ensuring safe work conditions** for staff (e.g. PPE available, cleaning and disinfection, etc.), as this is the most basic form of recognition that can be given, and until basic safety is met, any other recognition is unlikely to yield positive results.

Employees can be engaged and recognized in many creative and meaningful ways (Note: Ensure any recognition activity takes into account measures in place (e.g. no food sharing or close team huddles)):

- Small gestures: team t-shirts, daily quotes, thank you notes from administrator
- Check-in with staff frequently (ask about their day, how they are doing)
- Seek out external resources available for frontline workers (e.g. Headspace meditation app offering free one-year membership)
- Celebrate special days like birthdays, nurses week, PSW day, etc.
- Hide thank you messages across the home
- Create a peer to peer recognition board so staff can recognize each other for their achievements
- Frequently share messaging around mental health and wellbeing and resources available
- Facilitate frequent huddles / town halls (in person / virtual) to provide direct recognition and make leadership accessible to staff
- Capture compliments made by residents and their families and post them with a staff picture on the wall
- Create theme days to generate some "buzz" on-site, e.g. superhero dress up, trivia, sports days
- Facilitate pulse check engagement surveys to gauge how employees are feeling and providing a venue for anonymous feedback through online tools
- Involve residents in recognition by having them write thank you notes
- Have all leaders create a thank you video
- Have people in the community make a sidewalk chalk drawing to thank staff

Additional ideas can be found here: https://eversoundhq.com/blog/keeping-staff-morale-up-during-covid-19/

Important to know

Once an outbreak is declared, recognition and empathy take on an essential role in reassuring staff who are putting themselves and their families at risk. Prepare all leaders in the organization ahead of the outbreak:

- Ensure leaders recognize when a staff member is in distress or unwell
- Give leaders the information and tools they need to manage their team and keep them safe
- Train leaders on communication skills so they can reassure and motivate their teams

It is important to note however that staff recognition activities cannot in any circumstance replace or come at the expense of employee safety.

8.4 DECISION-MAKING

Certain situations in a pandemic call for increased **speed in decision making**. Examples include an outburst from a family member wanting to visit a resident, a resident showing symptoms, a fire alarm, no PPE available, staff shortage, limited financial resources, etc.

Ideally, all decisions made, either as part of pandemic preparedness and prevention or during an outbreak will occur as quickly as possible, while not compromising the quality and accuracy of the decisions being made. However, the person responsible for making this decision may not be available. It is therefore critical that decision making responsibilities and backup plans be defined for the pandemic. It is essential that division of **responsibilities are clear**, and paths of escalation are identified, e.g. if a decision cannot be reached.

Key questions to consider when it comes to decision making include:

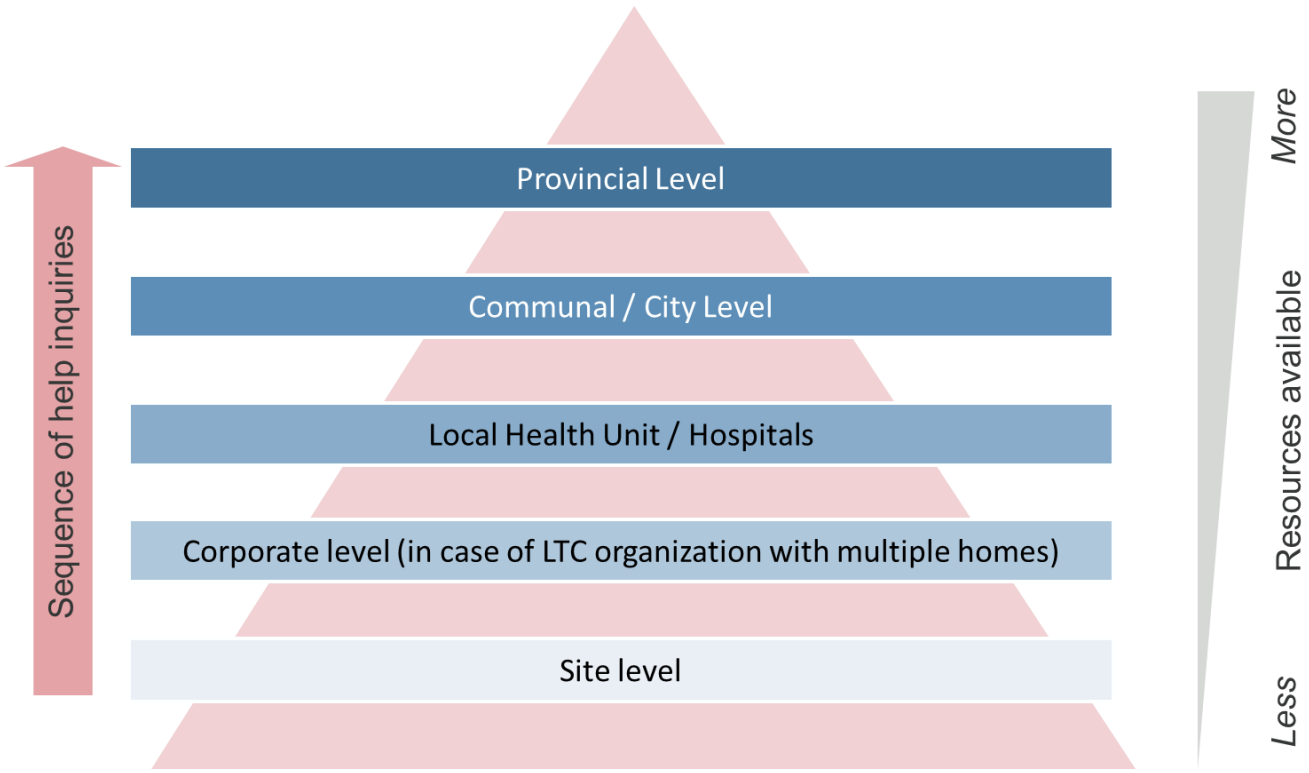
- What are the types of decisions that we may need to make throughout this pandemic?
- Consider previous similar experience (e.g. other outbreak) and learnings from peers who have had to make these decisions already during the pandemic
- What is the risk associated with this decision?
- For decisions with severe implications (e.g. life/death, potential to infect, etc.) it is likely that the decision will need to sit with a senior member of leadership or clinical staff
- Who is currently responsible for this decision? Should they be?
- Consider whether a decision can be reached in a timely manner, e.g. if need to make decision immediately at the bedside
- Who can act as a secondary decision-maker for this decision?
- Who needs to be consulted to make this decision? Who needs to be informed?
- What information is required to make this decision? Is it available?
- What decisions should we plan ahead for (e.g. create protocol for aggressive non-essential visitor at the entrance)?

Note that critical decisions can be informed by the Organization Risk Assessment and mitigation plans.

8.5 ASKING FOR HELP

One of the key elements of strong leadership in crisis is to recognize when it is time to ask for help and support. It is not a sign of weakness but the only possible way in many situations to preserve lives and the wellbeing of residents and staff.

It is important to understand who can provide help and what kind of help can be expected. An overview below shows the different levels of potential support. Not all levels are applicable to every situation (e.g. no Corporate level for standalone LTC homes). The order might also vary depending on situation.



It is important to stay proactive and ask for government support before the situation escalates. We suggest seeking external support if:

- The LTC home / organization has **exhausted all internal solutions** to turn around / improve the situation AND
- Not asking for external help will pose danger to the life and wellbeing of residents and/or staff

The section GOVERNMENT AND ADDITIONAL SUPPORT provides a more detailed overview of resources available through various bodies.

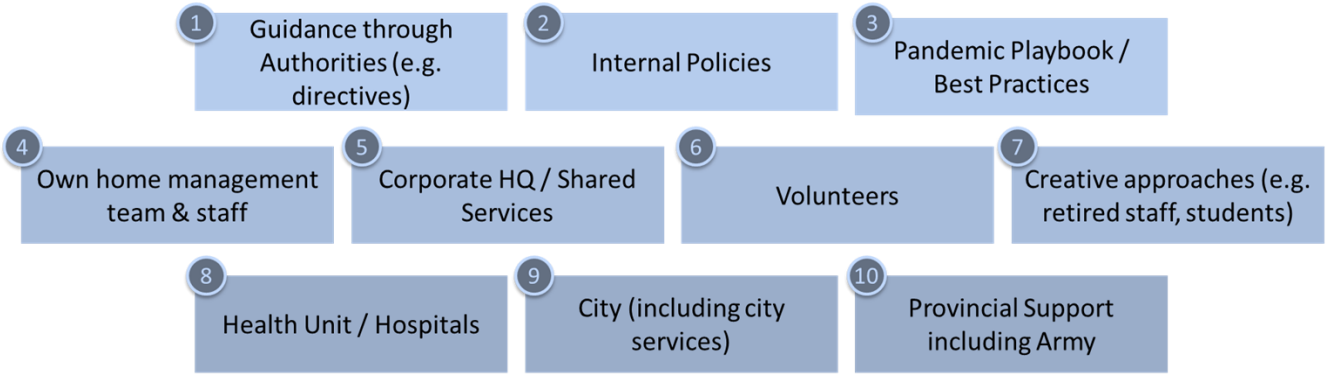
Asking for helping must be done through a clear communication that addresses as a minimum the following:

- What kind of help is required?
- Why this help is required (provide situation / issue(s) background and what has already been done)?
- How quickly is the help required?
- What are the consequences of not providing this help?

The process of asking for help can be made easier by being proactive, and starting conversations early in the pandemic with different parties to understand support available so as to incorporate in the facilities plans and procedures. Remember that in many cases, asking for help in a timely manner can save lives.

8.6 LEADERSHIP TOOLKIT

As a leader it is important to be aware of the tools available to turn around a critical situation or, even better, prevent it. The below overview shows a sample leadership tool kit for all LTCH leaders. Please note that toolkits might differ from organization to organization.



Guidance through Authorities (e.g. directives)	• MOH/MOHLTC directives address many burning topics but in some cases it might take some time for directives to be issued • In some cases, directives provide a minimum of what must be done, consider going further than directives suggest if meaningful
Internal Policies	• Internal policies provide guidance across nearly all aspects of operations but make sure to review the most critical ones to ensure alignment with latest pandemic information • Some policy changes might be required
Pandemic Playbook / Best Practices	• This playbook combines many best practices, but make sure that it is maintained up to date as knowledge about a pandemic constantly changes and thus best practices might evolve • Make sure to leverage other sources of best practices available
Home management team and staff	• The home management and staff is a fantastic lever if well deployed • Make sure to constantly maintain management and staff in best performance via recruiting, training, educating, and recognition
Corporate HQ / Shared Services	• If an LTC organization oversees several homes, there is a good chance that there are shared support services / HQ that can provide support • Use this additional tool and be clear about what support is required
Volunteers	• In some situations, volunteers can be a great support though there is a need to adhere to clear rules (e.g. cohorting, etc.). • If volunteers are not allowed to provide support in the home, there are still opportunities to leverage them e.g. for resident support from outside, via virtual communication and programming, etc.

Creative approaches (e.g. retired staff, students)	• Some resource pools might not be obvious and may include such resources as graduating students, retired nurses and PSWs • This may require some interaction with unions, depending on context
Health Unit / Hospitals	• Health Units can provide valuable guidance and support, identify potential areas for improvement and share best practices • Hospitals may provide support in acute cases or in situations with extreme staffing levels
City (including city services)	• There are a number of topics where the city / community can assist including but not limited to financial support, transportation services, emergency services, temporarily accommodation services (e.g. hotels, schools, etc.)
Provincial Support including Army	• Similar to the city, the province can lean in on many topics but with a stronger impact • Provincial authorities can also request extreme support solutions such as army support

9 GOVERNMENT AND ADDITIONAL SUPPORT

A pandemic puts unprecedented pressure on a long-term care organization, depleting its resources such as staff and supplies (e.g. PPE equipment), and posing a very high risk both to residents and team members caring for these residents. There are additional external / government supports that can help in this situation. These should be used when other alternatives have been exhausted. These include but are not limited to:

- Government (Municipal, Provincial and Federal authorities)
- Hospitals
- Army

WHEN DO EXTERNAL RESOURCES GET INVOLVED

There is a reactive and a proactive way when government and other external parties get involved. If government decides that a long-term care home / organization is not able to deal with the current pandemic situation on its own (especially in case of an outbreak), it may decide to get involved. This is a highly undesirable scenario meaning that the situation is already critical.

It is important to stay proactive and ask for government support before things escalate. Seeking external support is recommended if:

- The LTC home / organization has exhausted all internal solutions to turn around / improve the situation AND
- Not asking for external help will pose danger to the life and wellbeing of residents and/or staff

The most typical cases where external help would get involved are unresolvable shortages of PPE supplies, lack of staff (below minimal staffing) to maintain the minimal standards of care, and rapid increase in positive cases among residents and / or staff members.

TYPE OF SUPPORT AVAILABLE THROUGH EXTERNAL RESOURCES

Here are examples of possible support that can be provided by external parties. This list is not exhaustive and is intended to serve for illustrative purposes but captures most types of interventions to date in the current pandemic.

External organization	Possible external support
Government	**Municipal** • Bring in temporary leadership from other facilities (e.g. if ED/DOC are ill) or staff from the municipality • Financial support • Volunteers • Transportation • Lodging / Temporary accommodation • Escalation to Provincial and Federal authorities • Procurement support (e.g. PPE supplies) • Additional support including ITT services, HR, etc. **Provincial and Federal** • Escalation • Financial support • Home management resources / additional staff • Decision to provide support through other organizations e.g. hospitals • Decision to provide support through army • Procurement support (e.g. PPE supplies) • IPAC experts
Hospital	• Critical care for the most endangered residents • Accommodation of some or all residents on hospital premises (as additional capacity) • Additional staff • On-site experts (e.g. respiratory specialists) • Sharing PPE supplies
Army	• Additional staff (clinical support, care, etc.) • Additional PPE supplies • Field hospital deployment • Transportation

CONSIDERATIONS FOR HOMES WITH EXTERNAL SUPPORT

Homes must realize that the moment external support is involved, the home should have a clear plan to return to a state where they will not require this support. This may include hiring staff, putting new management in place, etc. depending on the situation that triggered the assistance. Where possible, the home should work with authorities to understand how much support they will get and for how long. The home should also ensure additional temporary staff's health and safety.

10 EMERGENCY PROCEDURES

10.1 FIRE

Important to know

A pandemic poses an unprecedented challenge for fire personnel, requiring additional protocols to preserve life safety. Typically, a fire plan includes a wide range of measures be performed to ensure fire preparedness and prevention as well as another set of measures in the event of fire outbreak.

Two changes are required to enhance fire preparedness and prevention and fire outbreak (during a viral pandemic):

- Due to the increased risk of viral exposure for residents and staff, normal fire planning and readiness protocols should be reduced to **essential** activities and with reduced frequency (as per table below).
- If a fire emergency occurs, consider unique constraints presented by the pandemic (e.g. suspected or infected residents or staff, re-located residents because of infection, etc.) to best protect all personnel. Use pandemic specific protection measures, e.g. cohorting, PPE, where possible

Note that emergency personnel may decide to forego some pandemic measures if the emergency calls for it (e.g. no time to don PPE), as a life-threatening emergency takes precedence over pandemic measures.

10.1.1 CHANGES IN STANDARD FIRE PROCEDURES

Please use the table below to reference revised fire procedures during a pandemic. The table below breaks out all changes to fire procedures in three distinct categories:

- No viral pandemic
- Preparedness / Prevention
- Outbreak

Category	Activity	No Pandemic	Preparedness / Prevention	Outbreak
Fire Drills	Conduct regular fire drills	Yes - Monthly	Yes – different frequency / extra pre-cautions (e.g. bi-monthly)	Suspend
	Conduct regular fire alarm reviews (post fire drill)	Yes – Monthly	Yes – different frequency / extra pre-cautions (e.g. bi-monthly)	Suspend
	Conduct table talk code Red exercise (silent drill)?	Yes - Monthly	Yes – different frequency (e.g. bi-monthly)	Suspend
Staffing	Plan for increased absenteeism based on risk of infection • Request full time hours from part time staff • Borrow local hospital personnel • Call on community volunteers (restrict tasks as needed)	Yes	Dependent on who and how many residents have pre-existing conditions, e.g. dementia, mobility restrictions - plan for a 10-20% staffing increase	Dependent on who and how many residents are infected or have pre-existing conditions, e.g. dementia, mobility restrictions - plan for a 20-30% staffing increase
Staff Education	Provide orientation to the Fire Safety plan for new employees	Yes, upon joining	Yes, if possible, to be completed at another location (or on-site with required precautions)	Yes, if possible, to be completed at another location (or on-site with required precautions)
	Re-instruct all employees on the Fire Safety Plan	Yes, annually	Yes, virtually	Suspend
	Learn location of pull stations (each employee)	Yes	Yes, as a part of orientation, with required precautions	Yes, as a part of orientation, with required precautions
Alternate Measures	Conduct fire safety patrol(s) and notify Fire Department / Alarm Monitoring Company	Yes	Yes, with protective measures	Yes, with protective measures
	Call “Code Red” and call 911	Yes	Yes	Yes

Category	Activity	No Pandemic	Preparedness / Prevention	Outbreak
Fire Panel Instructions	Send staff to resident floors	Yes	Yes, with protective measures	Yes, with protective measures
	Give information to Fire Department upon arrival	Yes	Yes, with protective measures – meet Fire Department outside	Yes, with protective measures – meet Fire Department outside
	Provide pandemic / outbreak details to fire Department upon arrival	N/A	Yes, with protective measures – meet Fire Department outside	Yes, with protective measures – meet Fire Department outside
	Announce "Code Red All Clear"	Yes	Yes	Yes
	Reset Fire Alarm system	Yes	Yes	Yes
	Reset mag locks	Yes	Yes	Yes
	Implement Fan Out plan – initiate evacuation	Yes	Yes, with protective measures	Yes, with protective measures
	Call Alliance Security – Declare end of emergency	Yes	Yes	Yes
Fire Watch Procedures	Patrol building (Fire Watch)	Yes	Yes, with protective measures	Yes, with protective measures
	Be aware of alarm procedures (all staff)	Yes	Yes, upon joining (e.g. necessary precautions for on-site staff)	Yes, upon joining (e.g. necessary precautions for on-site staff)
	Fire extinguishing equipment use training	Yes	Yes, upon joining (e.g. necessary precautions for on-site staff)	Suspend
Malfunctioning Equipment Fire Code Inspection	Notify Cornwall Fire Services (and Monitoring Agency if needed)	Yes	Yes	Yes
	Implement signage in the common areas of the building	Yes	Yes, with protective measures	Yes, with protective measures
	Repair malfunctioning equipment (through third party)	Yes	Yes, with protective measures, minimal number of vendors	Yes, with protective measures, minimal number of vendors
Fire Code Inspection	Perform "as required" Fire Code Inspection duties	Yes	Suspend	Suspend
	Perform "daily" Fire Code Inspection duties (e.g. alarm AC power lamp, central alarm, etc.)	Yes, daily	Yes, daily	Yes, daily
	Perform "monthly" Fire Code Inspection duties (e.g. portable extinguishers, standby power batteries, etc.)	Yes, monthly	Yes – different frequency / extra pre-cautions (e.g. bi-monthly)	Suspend
	Perform "annual" Fire Code Inspection duties (e.g. portable	Yes, annually	Yes, limited # of suppliers, with	Suspend

Category	Activity	No Pandemic	Preparedness / Prevention	Outbreak
	extinguisher maintenances, controls for air-handling systems used for vents, etc.)		protective measures	(until the end of the outbreak)

10.1.2 OUTBREAK-SPECIFIC GUIDANCE

In the event of a declared viral outbreak, enhanced safety precautions need to be taken due to various factors, e.g. suspected or infected staff or residents, re-located residents within the home because of infection, etc.

The following questions are to be answered for fire personnel arriving to handle an on-site fire emergency:

- **What is the location of all residents?** Provide the most up-to-date locations of all residents based on possible relocation to another space / unit / room because of pandemic outbreak procedures
- **Which residents are negative, suspected of being positive or positive?** Understanding resident condition and degree of mobility is essential.
- **Where is the location of all employees**? Are any employees absent who should be at work? If so, who is backing up whom regarding fire safety responsibilities. RISK: staff absence may be too great to fully execute all responsibilities.
- **Which staff are negative, suspected of being positive or positive?** It is important to know the level of mobility and condition of all staff to understand support requirements.
- Any additional questions that are asked by the Fire Department

In case of an emergency, the main SAVE guideline is applicable to staff members who discover the fire. Do not panic – your actions may save lives.

SAVE	
	SAVE anyone in immediate danger
	ALARM: Activate fire alarm (pull stations; call extension 4260)
	VENTILATION: Close doors and windows to fire activated room to contain smoke/fire gases
	EXTINGUISH OR EVACUATE: Extinguish fire or evacuate residents from the area

10.1.3 KEY PRINCIPLES FOR EVACUATION

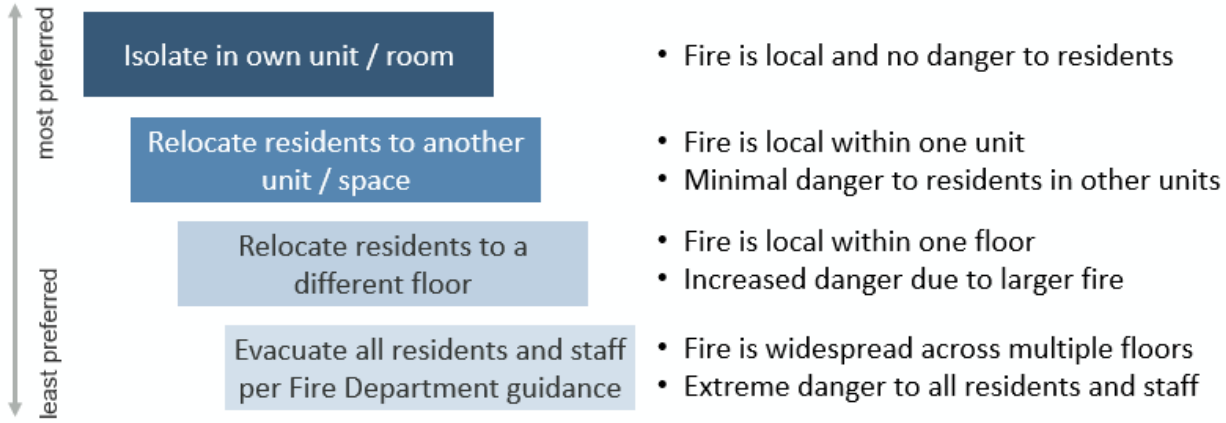
In the initial stages of discovering a fire, patient evacuation is always movement of **those closest to the area of origin first**, as per normal procedures.

When evacuating residents and staff, it is important to remember that all staff, residents and fire personnel are at increased risk to contact the virus and that ALL necessary precautions should be taken. The guidance below is general and should be adapted based on the situation.

Scenario	Suggested approach
One particular cohort of residents is endangered	• Evacuate this cohort of residents first • If their status is not known or they are known to be positive / suspected, a defined group of staff is required (to minimize infection to all groups) • Put in place personal protection for both sides as much as possible • Transport residents in a disinfected transportation vehicle to the prepared destination (if required) • Ensure cohorting of positive / negative residents at the target destination
No Particular cohort of residents is endangered	Staff will do the initial transportation of all residents to another zone while maintaining necessary precautions e.g. cohorting, PPE, etc. If it is determined that there is a need to **further transport residents beyond the pre-determined zone**, then Fire Department may assist with this movement. Precautions to consider in order to protect both Residents / Staff and Fire Department personnel: • **Cohort fire services personnel:** ensure that the same cohort of fire personnel transports the same cohort of residents (e.g. negative), another cohort of fire personnel to transport another cohort (e.g. positive) • Put in place **personal protective equipment** for all as much as possible • Transport residents in a **disinfected transportation** vehicle to the prepared destination (if required) • Ensure **cohorting of positive / negative residents** at the target destination • **Relocate the negative residents first only if** conditions have deteriorated and residents must be further evacuated horizontally or vertically a second time from the initial safe zone.

Please find below an overview of various transportation / evacuation scenarios in case of a fire, from most preferred to least preferred.

Fire Procedure logic (during an outbreak) : from most to least preferred



10.2 OTHER EMERGENCIES

In other emergencies (e.g. flood, bomb threat, code yellow, outage) during an outbreak, adhere to existing protocols in place while taking additional precautions (e.g. PPE, cohorting residents, physical distancing). Plans should be adjusted ahead of time to account for outbreak measures, for example:

- Adjust transportation guidelines for evacuation (disinfection)
- Code yellow, e.g. search positive rooms with PPE
- Code blue, e.g. CPR on positive resident with PPE
- Code black, e.g. evacuation in cohorts

11 TEMPLATES

11.1 PREVENTION AND PREPAREDNESS

11.1.1 MOH SCREENING TOOL

When to use	For every person entering the facility
Responsible	Screener
Source	http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_screening_guidance.pdf

Screening Questions

1. Do you have any of the following **new or worsening** symptoms or signs?

New or worsening cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Runny nose, sneezing or nasal congestion (in absence of underlying reasons for symptoms such as seasonal allergies and post nasal drip)	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
New smell or taste disorder(s)	☐ Yes	☐ No
Nausea/vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Unexplained fatigue/malaise	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

2. Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days?
   ☐ Yes ☐ No
3. Do you have a fever?
   ☐ Yes ☐ No
4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?
   ☐ Yes – go to question 5 ☐ No – screening complete
5. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures (AGMPs)) when you had close contact with a suspected or confirmed case of COVID-19?
   ☐ Yes ☐ No

If the individual passes screening questions 1 to 5 (as per results section below) then TAKE TEMPERATURE. A fever is a temperature of 37.8 °C or greater.

Results of Screening Questions:

- If the individual answers **NO to all questions from 1 through 4 and they do not have a fever,** they have passed and can enter the home. They need to wear a mask to enter the home and should be told to self-monitor for symptoms and be reminded about required re-screening at the end of their day/shift or when they leave the home.
- If the individual answers **YES to any question from 1 through 3,** they have not passed and **cannot** enter the home. They should go home to self-isolate immediately. Staff should contact their manager/immediate supervisor. Essential visitors should be told to contact a primary care provider, local public health unit or Telehealth to discuss their symptoms and/or exposure and seek advice on testing.
- If the individual answers **YES to question 4 and YES to question 5, and they do not have a fever**, they have passed and can enter the home. They need to wear a mask to enter the home and should be told to self-monitor for symptoms and be reminded about required re-screening at the end of their day/shift or when they leave the home.
- If the individual answers **YES to question 4 and NO to question 5,** they have not passed screening and **cannot** enter the home. They should go home to self-isolate immediately. Staff should contact their manager/immediate supervisor. Essential visitors should be told to contact a primary care provider, local public health unit or Telehealth to discuss their symptoms and/or exposure and seek advice on testing.

Note:

- As per Regulations 146/20 and 158/20 of the *Emergency Management and Civil Protection Act*, employees of LTCHs and RHs are not to work in more than one LTCH, RH or health care setting, and should be screened appropriately by the home / employer.

11.1.2 STAFF SCREENING TRACKER

https://drive.google.com/file/d/10kSmmR7-CIcEEQhCxRLbNyuMxJ6nlh1U/view

Staff Screening Tracker

Legend: Passed: P-A = NO to all questions #1-#4 OR P-B = NO to #1-3 & YES to #4 & #5
Failed: F-A = YES to any question #1-#3 AND/OR F-B = YES to #4 & NO to #5

Date	#1 Screening Time	Staff Name Printed	Temp	Screening result P-A or P-B; F-A and/or F-B	Name of Staff conducting #1 Screening	#2 Screening Time	Temp	Screening result P-A or P-B; F-A and/or F-B	Name of staff conducting #2 screening
4/28/20	*8:45am*	*Jane Doe*	*36.5*	*P-A*	*Joe Smith*	*12:45pm*	*36.7*	*P-A*	*Joe Smith*

11.1.3 RESIDENT SCREENING TRACKER

https://drive.google.com/file/d/10kSmmR7-CIcEEQhCxRLbNyuMxJ6nlh1U/view

Resident Screening Tracker

Date	# 1 Screening Time	Resident Name Printed	Temp	Screening result (pass or fail)	Name of Staff conducting #1 Screening	# 2 Screening Time	Name of staff conducting # 2 screening	Temp	Screening result (pass or fail)

COVID -19 – VISITOR SCREENING FORM

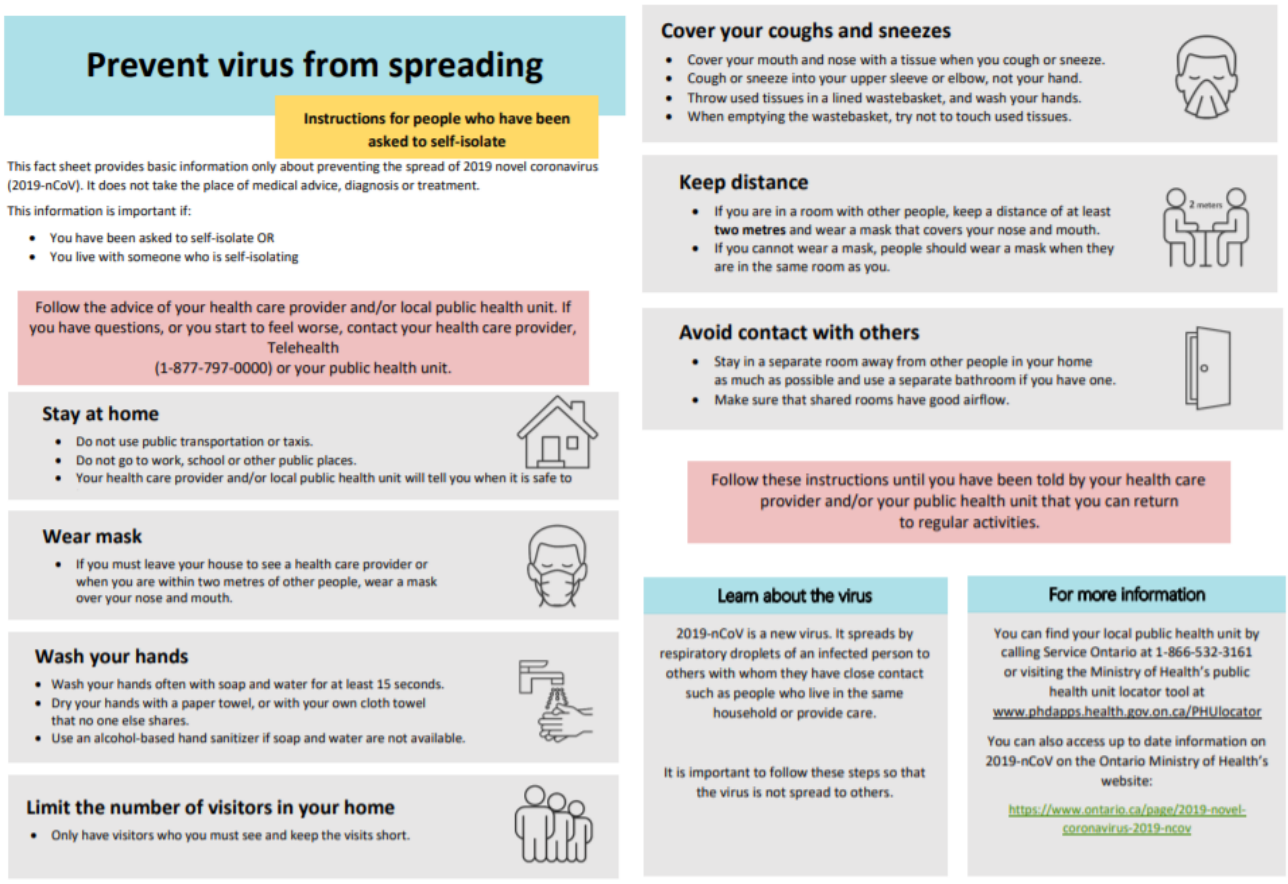
DATE	NAME	REASON FOR VISIT/RESIDENT	DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: FEVER, NEW ONSET COUGH, WORSENING CHRONIC COUGH, SHORTNESS OF BREATH, ORD DIFFICULTY BREATHING?		DID YOU HAVE CLOSE CONTCT WITH ANYONE WITH ACUTE RESPOIRATORY ILLNESS OR TRAVELLED OUTSIDE OF CANADA IN THE PAST 14 DAYS?		DO YOU HAVE A CONFIRMED CASE OF COVID-19 OR HAD CLOSE CONTACT WITH A CONFIRMED COVID-19 CASE?		DO YOU HAVE ANY TWO (2) OR MORE OF THE SYMPTOMS LISTED BELOW? Sore throat, Hoarse voice, difficulty swallowing, decrease or lose of sense of taste or smell, chills, headaches, unexplained fatigue/malaise, diarrhea, abdominal pain, nausea/vomiting, pink eye, runny nose/sneezing without other known cause, nasal congestion without other known cause.		TIME	TEMPERATURE IF 37.8⁰ OR GREATER PERSON IS NOT PERMITTED TO ENTER	TIME	TEMPERATURE IF 37.8⁰ OR GREATER STAFF MUST BE SENT HOME	MASK Dispensed	
			YES	NO	YES	NO	YES	NO	YES	NO					1st	2nd

IF YES IS ANSWERED TO ANY OF THE ABOVE QUESTIONS – VISITOR AND STAFF ARE RESTRICTED FROM ENTERING THE LODGE

May 14, 2020

11.1.5 FAILED SCREENING MATERIALS

When to use	Staff or visitor fails a screening
Responsible	Screener
Source	https://www.oha.com/Bulletins/Instruction_Sheet_Coronavirus_Investigation_2020-02-08%20V2.pdf



Prevent virus from spreading

Instructions for people who have been asked to self-isolate

This fact sheet provides basic information only about preventing the spread of 2019 novel coronavirus (2019-nCoV). It does not take the place of medical advice, diagnosis or treatment.

This information is important if:

- You have been asked to self-isolate OR
- You live with someone who is self-isolating

Follow the advice of your health care provider and/or local public health unit. If you have questions, or you start to feel worse, contact your health care provider, Telehealth (1-877-797-0000) or your public health unit.

Stay at home

- Do not use public transportation or taxis.
- Do not go to work, school or other public places.
- Your health care provider and/or local public health unit will tell you when it is safe to

Wear mask

- If you must leave your house to see a health care provider or when you are within two metres of other people, wear a mask over your nose and mouth.

Wash your hands

- Wash your hands often with soap and water for at least 15 seconds.
- Dry your hands with a paper towel, or with your own cloth towel that no one else shares.
- Use an alcohol-based hand sanitizer if soap and water are not available.

Limit the number of visitors in your home

- Only have visitors who you must see and keep the visits short.

Cover your coughs and sneezes

- Cover your mouth and nose with a tissue when you cough or sneeze.
- Cough or sneeze into your upper sleeve or elbow, not your hand.
- Throw used tissues in a lined wastebasket, and wash your hands.
- When emptying the wastebasket, try not to touch used tissues.

Keep distance

- If you are in a room with other people, keep a distance of at least **two metres** and wear a mask that covers your nose and mouth.
- If you cannot wear a mask, people should wear a mask when they are in the same room as you.

Avoid contact with others

- Stay in a separate room away from other people in your home as much as possible and use a separate bathroom if you have one.
- Make sure that shared rooms have good airflow.

Follow these instructions until you have been told by your health care provider and/or your public health unit that you can return to regular activities.

Learn about the virus

2019-nCoV is a new virus. It spreads by respiratory droplets of an infected person to others with whom they have close contact such as people who live in the same household or provide care.

It is important to follow these steps so that the virus is not spread to others.

For more information

You can find your local public health unit by calling Service Ontario at 1-866-532-3161 or visiting the Ministry of Health's public health unit locator tool at www.phdapps.health.gov.on.ca/PHUlocator

You can also access up to date information on 2019-nCoV on the Ontario Ministry of Health's website:

https://www.ontario.ca/page/2019-novel-coronavirus-2019-ncov

11.1.6 IPC CHECKLIST FOR LONG-TERM CARE

When to use	Prevention and Preparedness, Outbreak
Responsible	IPC lead
Source	https://www.publichealthontario.ca/-/media/documents/ncov/ipac/covid-19-ipack-checklist-ltcrh.pdf?la=en Note: Checklist is several pages long, see link

1. Entrance

1	Entrance	Yes	No
1.1	**Passive Screening and Signage:** There is signage at the entrance prompting health care workers (HCWs), other staff, and essential visitors to self-identify if they have signs and symptoms of COVID-19. There are also: • Reminders to perform hand hygiene • Reminders to follow respiratory etiquette • Steps to be taken if COVID-19 is suspected or confirmed • Access to alcohol based hand rub (ABHR) in an alcohol concentration of 70 – 90 %, tissues, no touch waste receptacles and signage for proper mask use	☐	☐
1.2	**Active Screening:** Using the COVID-19 Screening Checklist, there is a screener present at the entrance to actively screen all HCWs, other staff and essential visitors, with the exception of emergency first responders, for signs and symptoms (including taking temperatures) as they enter the building. Active screening procedure occurs 24 hours a day, seven days a week. Screeners ask all HCWs, other staff and essential visitors if they are working or visiting at other facilities or homes. • Those who respond yes to working/visiting in another facility are not to enter the facility and are to contact their immediate manager/supervisor to discuss a work plan.	☐	☐
1.3	**Ongoing Monitoring:** All HCWs, other staff, and essential visitors are to be screened twice daily, including temperature checks. HCWs and staff screening is done at the beginning and end of the day or shift. Essential visitor screening is done upon entry and exiting the home. See How to Self-Monitor.	☐	☐
1.4	HCWs, other staff and essential visitors who screen positive are: • not allowed in the home • to notify their immediate manager/supervisor and/or Occupational Health and Safety Department. • instructed to contact their health care provider, Telehealth (1-866-797-0000) or their local public health unit.	☐	☐
1.5	• There is a process to record who has entered and exited the home. • There is a process to identify who is an essential visitor (full name, contact information, the resident they are visiting, and the in/out time).	☐	☐
1.6	The screener wears – at a minimum—a mask, eye protection and gloves OR is behind a Plexiglas partition.	☐	☐

11.1.7 CDC PPE BURN RATE CALCULATOR

When to use	Prevention (Supply Management), Outbreak
Responsible	Administrator or designate
Source	https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/PPE-Burn-Rate-Calculator.xlsx

Box A		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
		XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020
		How Many COVID-19 Patients are Being Treated at Start of the Day? Enter Below.													
Number of Suspected and Confirmed COVID-19 Patients		20	20	28	26	35	36	40	40						
Type of PPE	Size/Brand	How Many Full Boxes Are Remaining at Start of the Day? Enter Below.													
Gowns	Size 1	500	475	400	350										
	Size 2														
	Size 3														
Gloves	small														
	medium														
	large														
	extra large														
Respirators															
Surgical Masks															
Face Shields															
Other	1														
Other	2														
Other	3														
Other	4														
Other	5														

11.1.8 DELIVERY FORM

When to use	For all items received for residents, in prevention and outbreak
Responsible	Supply reception
Source	Custom

Delivery Form

This section is to be filled out by **person making the delivery**. Please place it with your delivery so we are able to better track incoming packages. Using clear plastic bags

Resident Name & Room Number:

Date:

Time delivered:

Delivered by:

This section is to be filled out **by Administration**.

Resident Name & Room Number:

Date:

Wait time:

Delivery time:

Form to be returned to reception.

11.1.9 PROCESS SHEET: MANAGING RESIDENT DEATHS IN LTC DURING COVID-19

Source: https://bcb.92b.myftpupload.com/wp-content/uploads/2020/04/LTC-process-sheetA13.pdf

Managing Resident Deaths in Long-Term Care (LTC) during COVID-19

The following guideline provides steps for the Managing Resident Deaths Team (MRDT) members to manage all deaths of LTC home residents, including COVID-19.

1 Death Pronouncement: MRDT

- Contact family – work with the family to confirm funeral home (FH) as soon as possible (within three hours). If needed, use funeral home finder to assist in determining a funeral home.
  - Obtain the family contact information—Cell phone number
  - Obtain FH contact information
  - Request that the family member with responsibility for funeral planning contact the FH promptly
- Contact funeral home and provide family contact information.
  - Indicate to FH if it is a COVID-19 death (confirmed or suspected)
  - If your facility does not have a supply of body bags, let the FH know
  - Work together to plan for release into the care of the FH
- If no family or Next of Kin, complete applicable section on Office of the Chief Coroner (OCC) Managing Resident Deaths Report (MRDR) and contact OCC Team at:
  - Phone: Toll Free: 1 (833) 915-0868 / Local (Toronto): 1 (647) 792-0440
  - Email: occteam@ontario.ca

2 Complete MRDR Package: MRDT

- The MRDR package should be completed concurrently with Step 1 (i.e. within the three-hour time period)
- Complete the Institutional Patient Death Record (IPDR) using the template provided instead of the on-line portal.
  - This is a change during the period of COVID-19 outbreak
- Engage promptly with the attending clinician for information and guidance on completion of the MRDR Cause of Death section
  - Obtain both the immediate cause of death and the underlying cause of death (if applicable)

3 Email or fax to OCC team

- Send MRDR immediately after completion
- Email: occteam@ontario.ca
- Phone: Toll Free: 1 (833) 915-0868 / Local: (Toronto): 1 (647) 792-0440 / Fax: 1 (888) 247-1845

4 Prepare for release to the Funeral Service Provider: MRDT

- Meet funeral service provider outside at the release area to obtain the FH stretcher
- Take FH stretcher to the location of the resident
- Move deceased resident into a leak proof body bag and onto the FH stretcher
  - if not available, the FH will provide a body bag when they arrive outside the facility.
- ***It is critical*** to ensure identification arm band is present on resident with matching labeling on outside of body bag.
- If positive or presumed COVID-19 case, label "COVID-19" on the body bag
- Prior to moving the deceased resident from the room, ensure the body bag is completely wiped down with a disinfectant solution (a hospital-grade disinfectant or a diluted concentration of bleach)

5 Release: MRDT

- FH staff remain outside of the facility
- Ensure resident is in body bag with identification labelling on outside
- At point of release from the facility ensure the body bag is completely wiped down with a disinfectant solution (a hospital-grade disinfectant or a diluted concentration of bleach)
- Logbook release as per protocol
- Transfer stretcher to FH outside the facility– no family in attendance
- FH transfers to vehicle

11.1.10 MANAGING RESIDENT DEATH REPORT FORM

When to use	Throughout pandemic, until instructed otherwise
Responsible	MRDT
Source	https://bcb.92b.myftpupload.com/wp-content/uploads/2020/04/Managing-Resident-Deaths-and-IPDR-Form_LTC.pdf Note: Actual form is 3 pages – use link to access complete form

Submit Form

Ontario

Managing Resident Deaths Report Form - Long-Term Care Homes

for Office of the Chief Coroner (OCC) Completion of Medical Certificate of Death

Please complete this template for deaths occurring in your facility and submit to the OCC by one of the following methods:

Email: save and send the completed report as an email attachment to occteam@ontario.ca or send by email by clicking on "Submit Form" at top right corner of the form.

Secure Web Form: submit the completed report as an attachment in the OCC-OFPS Secure Web Form

Fax: 1-888-247-1845

If you have questions, please contact: 1-833-915-0868 (Toll Free) or 647-792-0440 (Local – Toronto)

Institution:

Long-Term Care Facility where death occurred:

City, town or township: Regional municipality or county:

Long-Term Care (LTC) staff reporting:

Name: Role/Title:

Phone number: Email:

Clinician providing information on cause of death:

Cell phone number:

Deceased:

Last name: First and middle names:

Date of Death (yyyy/mm/dd): Date of Birth (yyyy/mm/dd):

Age: Sex:

LTC ID #:

04/09/2020 1

11.1.11 RESIDENT GET TO KNOW ME SHEET

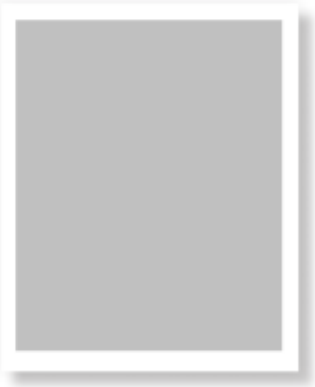
When to use	Prevention
Responsible	Recreation staff (in collaboration with Nursing and Care staff)
Source	https://alzheimer.ca/sites/default/files/files/national/core-lit-brochures/all_about_me_a_conversation_starter_e.pdf

All About Me
A Conversation Starter

Last date revised:

I like to be called…

In the past I…



A typical day for me could include…

I enjoy…

I don't like…

Who knows me best?

11.1.12 SIGNAGE: NON-ESSENTIAL VISITORS

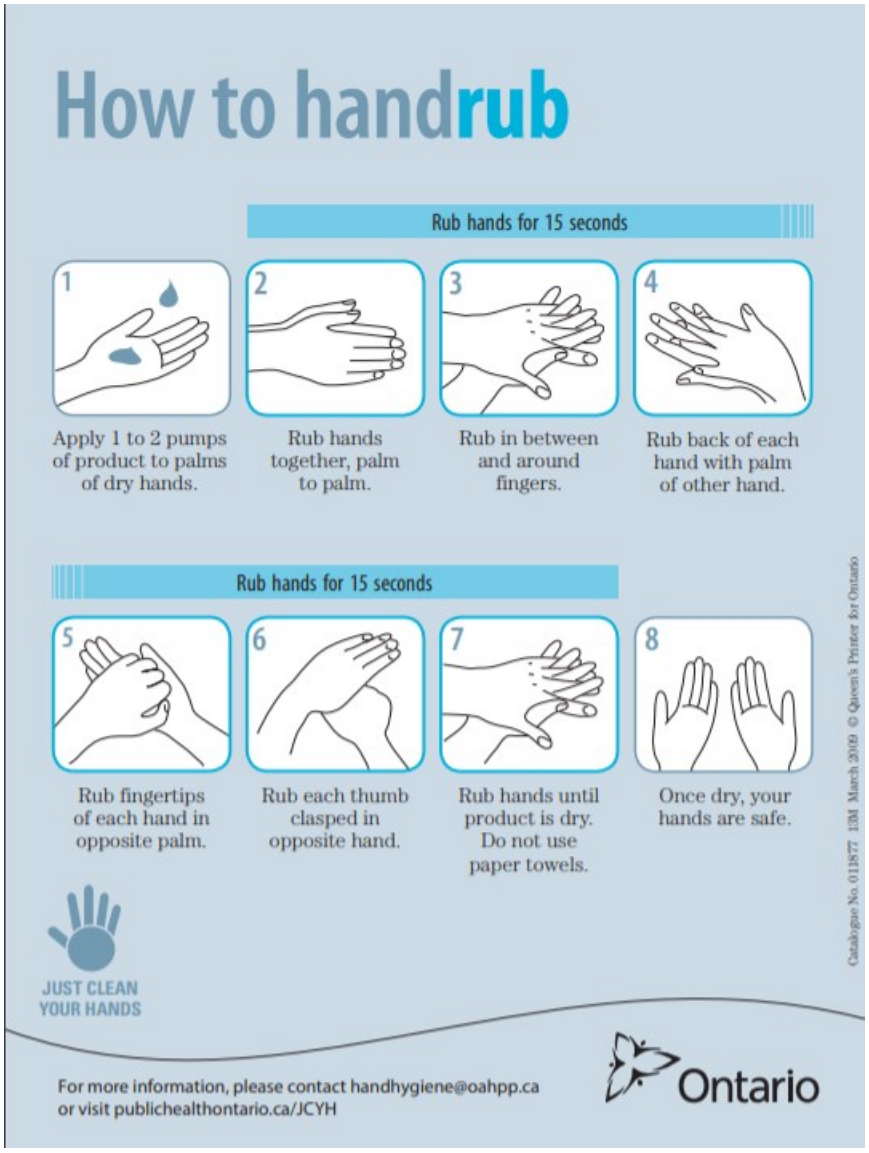
When to use	Prevention & Outbreak
Responsible	IPAC Officer
Source	https://www.orcaretirement.com/wp-content/uploads/EN-LTCH-v02.2-2020-03-13-Shared.pdf

11.1.13 SIGNAGE: HANDWASHING

When to use	Prevention & Outbreak
Responsible	IPAC Officer
Source	https://www.publichealthontario.ca/-/media/documents/j/2009/jcyh-handwash.pdf?la=en

11.1.14 SIGNAGE: HANDRUBBING

When to use	Prevention & Outbreak
Responsible	IPAC Officer
Source	https://www.publichealthontario.ca/-/media/documents/j/2009/jcyh-handrub.pdf?la=en



11.1.15 SIGNAGE: PRECAUTIONS OUTSIDE THE HOME

When to use	Prevention & Outbreak
Responsible	IPAC Officer
Source	https://files.ontario.ca/mltsd-2/mltsd-essential-sector-posters-long-term-care-worker-en-8.5x11-2020-04-30.pdf

11.1.16 SIGNAGE: CAREGIVERS PROTECTING YOURSELF

When to use	Prevention & Outbreak
Responsible	IPAC Officer
Source	https://www.rgptoronto.ca/wp-content/uploads/2020/03/COVID-19-Caregiver-Poster.pdf

11.1.17 INSTRUCTIONS: PPE WASHING

When to use	Prevention & Outbreak
Responsible	Environmental Manager
Source	https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html

REUSABLE GOWNS

Method	Product(s)	Process	Additional considerations
Commercial/ industrial laundry machines	Laundry detergents	Follow instructions from the washer/dryer manufacturer. Use hot water (70–80°C X 10 min) [158–176°F]) and an approved laundry detergent. Dry linens completely in a commercial dryer.	Gowns with small holes, tears, or missing fastening ties need to be mended and those that are thin or ripped need to be discarded.

EYE PROTECTION

Type of equipment	Reprocessing steps	Disinfectant Product Options	Considerations / Additional Guidance
Reusable goggles or face shield	1. Immerse in or wipe with neutral detergent and warm water solution, use mechanical action to remove any visible soiling, then quickly rinse with clean water; rinse if needed. 2. Immerse in or wipe with hospital disinfectant solution for the required contact time. 3. Rinse with clean water (sink if available or by immersing in a bucket of clean water) to remove any residue. 4. Fully dry (air dry or use clean absorbent towels).	Manufacturers should be consulted for their guidance and experience in disinfecting their respective products.	Chlorine-based disinfectant (0.1% chlorine solution) recommended over alcohol as alcohol may damage and discolor plastic and deteriorate glues over time; note that it may also remove anti-glare and anti-fogging properties of the eye protection. **Note:** Solutions must be regularly replaced as they will quickly become contaminated. See guidance on how to prepare 0.1% chlorine solution.

Note: Regarding non-reusable face shields that are being cleaned as part of a conservation strategy, it is not necessary to clean the strap, Velcro, foam, or other non-patient facing, textured components of the face shield. If these components are visibly soiled/contaminated, the face shield should be discarded. ***Cleaning of face shields should focus on the area most likely to be contaminated, which is the outer surface of the shield. Non-outward facing components such as straps and foam are not meant to be disinfected, and are not expected to be contaminated with typical use as they do not directly face a potential infected source.***

11.2 OUTBREAK RESPONSE

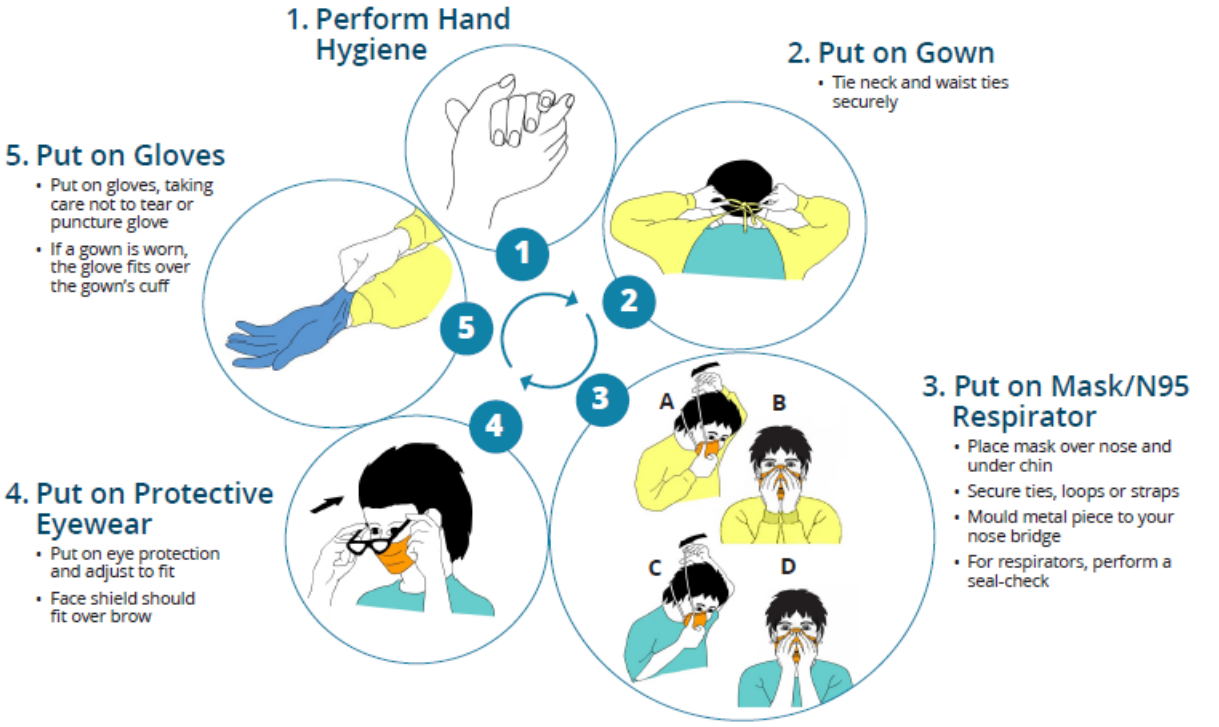
11.2.1 PPE DONNING AND DOFFING INSTRUCTIONS

When to use	Prevention (Education purposes), Suspected or Confirmed Case
Responsible	IPC lead or designate
Source	https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ppe-recommended-steps.pdf?la=en

Recommended Steps:

Putting On Personal Protective Equipment (PPE)

Public Health Ontario | Santé publique Ontario



For more information, please contact Public Health Ontario's Infection Prevention and Control Department at ipac@oahpp.ca or visit www.publichealthontario.ca.

Ontario

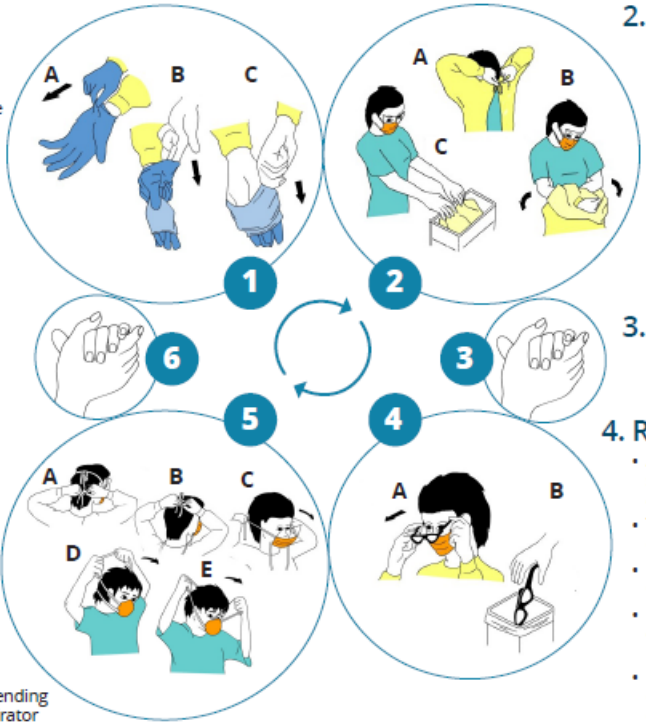
Recommended Steps:

Taking Off Personal Protective Equipment (PPE)

Public Health Ontario | Santé publique Ontario

1. Remove Gloves

- Remove gloves using a glove-to-glove / skin-to-skin technique
- Grasp outside edge near the wrist and peel away, rolling the glove inside-out
- Reach under the second glove and peel away
- Discard immediately into waste receptacle



2. Remove Gown

- Remove gown in a manner that prevents contamination of clothing or skin
- Starting with waist ties, then neck ties, pull the gown forward from the neck ties and roll it so that the contaminated outside of the gown is to the inside. Roll off the arms into a bundle, then discarded immediately in a manner that minimizes air disturbance.

3. Perform Hand Hygiene

4. Remove Eye Protection

- Arms of goggles and headband of face shields are considered to be 'clean' and may be touched with the hands
- The front of goggles/face shield is considered to be contaminated
- Remove eye protection by handling ear loops, sides or back only
- Discard into waste receptacle or into appropriate container to be sent for reprocessing
- Personally-owned eyewear may be cleaned by the individual after each use

5. Remove Mask/ N95 Respirator

- Ties/ear loops/straps are considered 'clean' and may be touched with hands
- The front of the mask/ respirator is considered to be contaminated
- Untie bottom tie then top tie, or grasp straps or ear loops
- Pull forward off the head, bending forward to allow mask/respirator to fall away from the face
- Discard immediately into waste receptacle

6. Perform Hand Hygiene

This is an excerpt from Routine Practices and Additional Precautions In All Health Care Settings (Appendix L) and was reformatted for ease of use.

Ontario

11.2.2 LINE LISTING EXAMPLE

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/reference/RESP_Infectn_ctrl_guide_LTC_2018_en.pdf

Respiratory Outbreak Line Listing Form

Check one	Data:	☐	Investigation Name:		Case Definition:
	Resident Data:	☐	Investigation Number:		

Case Identification				Symptoms														Complications				Specimens/ Diagnostics					Prophylaxis/ Treatment			
Case (Sequential)	Name and Locatio n (Floor, Room, Bed)	Gender	Age	Onset of First Symptoms (d/m)	Abnormal temperature (°C)	Dry cough (new)	Runny nose/sneezing	Nasal Congestion/Stuffy Nose	Sore Throat	Hoarseness/Difficulty	Chills	Myalgia	Malaise	Productive Cough (new)	Headache	Poor appetite	Other (please specify)	Bronchitis (d/m)	Pneumonia (d/m)	Hospitalization (d/m)	Death (d/m)	Nasopharyngeal swab (d/m)	Nasopharyngeal Swab Result date	X-Ray confirmed pneumonia (Y/N)	Other – Specify (d/m)	Result (d/m)	Antiviral Medication	Flu vaccination (d/m)	Pneumo vaccine (d/m)	Antibiotic (d/m)

Comments:

11.2.3 LINE LISTING CONTENTS

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/reference/RESP_Infectn_ctrl_guide_LTC_2018_en.pdf

Resident Surveillance
• Name of resident. • Age. • Location in home such as unit, room, bed number. • Date of onset of symptoms. • Signs and symptoms relating to the case definition. • Date started and treatment given such as antibiotics or antiviral medications. • Diagnostic tests such as x-rays. • Samples taken including date and results if known (e.g. nasopharyngeal swab). • Immunization history for influenza. • If the resident was hospitalized – date and location of hospitalization. • If deceased (include date and cause of death). • If the resident was isolated, the start date of isolation. • Date illness resolved. • Date on which antiviral prophylaxis was initiated (if applicable). • Complications (e.g. pneumonia).
Staff Surveillance
• Staff identification. • Work assignments in the home including notation of assigned wards/units. • Date of onset. • Signs and symptoms relating to the case definition. • Antiviral medication given for treatment. • Influenza immunization history. • Any diagnostic tests including results if available. • Last day of work of ill staff member. • Date of recovery. • Date returned to work.

11.2.4 CONTACT TRACING

https://orcaretirement.com/members/wp-content/uploads/2020/04/Sample-Contact-Mapping-and-Timeline-Tool-April-24-2020.pdf

Positive COVID-19 Tracker
April 24, 2020

Property Name	
Resident/Employee:	

Timeline

Date of Event	Details (Contact with whom, symptoms, testing etc)
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]
[Enter Date]	[Enter Details]

Actions Taken	Date
1. Received confirmation from hospital, physician, Public health	
2. Contact surfaces disinfected (resident/team member)- additional sweep	
3. Contact Mapping completed (resident/team member)	
4. Isolation and PPE procedures in place	
5. Staffing (confirmation of cohorting in place)	
6. Compliance checklist - review vulnerabilities	
7. Line list of Residents (protocol in place)	
8. Public Health/CMO Direction received	
9. Comunication: Staff/Resident/Families	

Positive COVID-19 Tracker
April 24, 2020

Guidelines

Instructions:
1. Map out each shift starting from the last shift, to 72 hours prior to symptoms start
2. Call staff member - walk through their routine, close contact with any staff members and any residents they provided care to

Close contact is defined as :
1. Have you had direct contact with or were within 2 meters/6 feet of an employee who is now symptomatic, been tested for, or confirmed COVID19?
2. Have you had direct contact with secretions i.e. coughed on, been tested for, or confirmed COVID19 or has cold/flu like symptoms?
3. Did you take any breaks with other staff (staff member breaks should not be taken together)?
4. Do you car pool or live with another staff member?
5. Close contact without wearing the appropriate PPE?
6. Do you disinfect any tools before/after use and hand hygiene implemented?

Staff Member Contact Mapping Questions:
1. Did you shake hands, hug other staff at all during your shift?
2. What PPE were you wearing during each interaction and while onsite?
3. Did you stand/sit within less than 6 feet of other staff?
4. Did a staff member cough, sneeze on you/near you?
5. Did you provide any care together to a resident?
6. Are you having any COVID symptoms (typical/atypical)?

Contact Mapping

Staff Member	[Enter Date]	[Enter Date]	[Enter Date]	[Enter Date]	[Enter Date]	[Enter Date]	Role/Relationship to Confirmed Case	Physical Distancing Maintained	Close Contact (Y/N)	Type of Contact (details)	Declaration Signed (Y/N)	COVID-19 Testing Date	COVID-19 Results & Date	Self isolate start date:	Self isolation End date (15th day)	Symptoms Check Twice Daily

Resident Contact Mapping

Staff Member	[Enter Date]	[Enter Date]	[Enter Date]	[Enter Date]	[Enter Date]	[Enter Date]		Physical Distancing Maintained	Close Contact (Y/N)	Type of Contact (details)	Declaration Signed (Y/N)	COVID-19 Testing Date	COVID-19 Results & Date	Self isolate start date:	Self isolation End date (15th day)	Symptoms Check Twice Daily

11.2.5 EDUCATION MATERIALS FOR DROPLET AND CONTACT PRECAUTIONS

When to use	Education, Suspected or Confirmed Case
Responsible	IPC lead or designate
Source	https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ipac-additional-precautions-non-acute-care.pdf?la=en

Public Health Ontario | Santé publique Ontario

Coronavirus Disease 2019 (COVID-19)

Droplet and Contact Precautions Non-Acute Care Facilities

This document was adapted from the Routine Practices Additional Precautions for the management of COVID-19 for health care workers. For more information, please contact the Infection Prevention and Control department at Public Health Ontario at ipac@oahpp.ca.

Hand Hygiene

Hand hygiene is performed:

- Before and after each resident contact.
- Before performing invasive procedures.
- Before preparing, handling, serving or eating food.
- After care involving body fluids and before moving to another activity.
- Before putting on and after taking off gloves and other PPE.
- After personal body functions (e.g., blowing one's nose).
- Whenever hands come into contact with secretions, excretions, blood and body fluids.
- After contact with items in the resident's environment.
- Whenever there is doubt about the necessity for doing so.

Resident Placement

- Single room with own toileting facilities.
- Door may remain open.
- Perform hand hygiene on entering and leaving the room.

Environment and Equipment

- Dedicate routine equipment to the resident if possible (e.g., stethoscope, thermometer).
- Clean and disinfect all equipment before it is used for another resident.
- All high-touch surfaces in the resident's room must be cleaned twice daily.

Personal Protective Equipment (PPE)

- Wear a mask and eye protection or face shield within 2 meters of the resident.
- Wear a long-sleeved gown for direct care* when skin or clothing may become contaminated.
- Wear gloves for direct care*.
- **Wearing gloves is NOT a substitute for hand hygiene**

On leaving the room or after performing direct care*:

- Remove gloves and gown and perform hand hygiene.
- Remove eye protection and mask and perform hand hygiene.

For more see: Recommended Steps for Putting on and Taking off PPE.

Resident Transport

- Avoid any unnecessary transport of resident outside of room.
- Resident to wear a mask during transport.
- Only if the resident cannot tolerate wearing a mask, transport staff should wear a mask and eye protection.
- Transport staff should consult with the facility IPAC designate for additional instructions.
- Clean and disinfect equipment used for transportation after use.

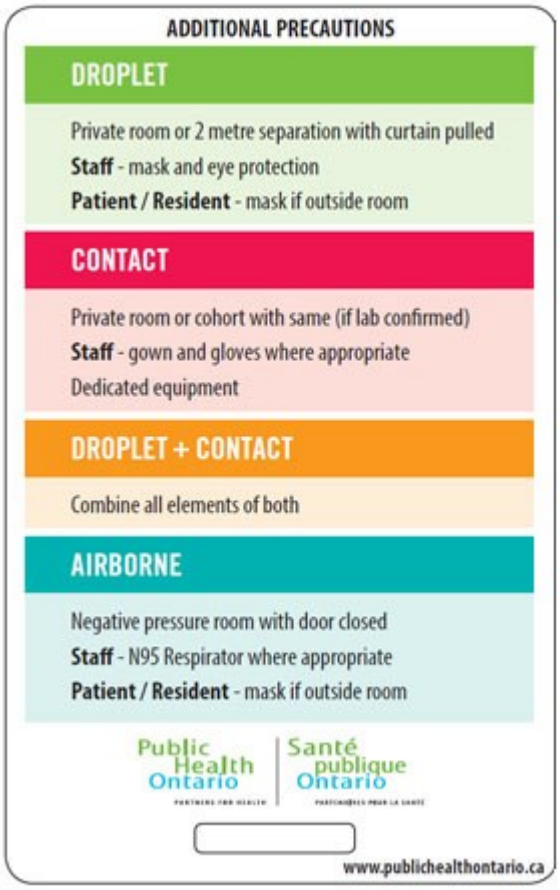
Visitors

- Visitors must perform hand hygiene before entry and on leaving the room.
- Visitors to wear a mask, eye protection, gloves and a long-sleeved gown when entering the room of a resident with COVID-19.
- Visitors to remove protective apparel upon leaving the room.

*** Direct Care:** Providing hands-on care, such as bathing, washing, turning the resident, changing clothing, continence care, dressing changes, care of open wounds/lesions or toileting. Feeding and pushing a wheelchair are not classified as direct care.

11.2.6 PERSONAL HANDOUTS FOR DROPLET AND CONTACT PRECAUTIONS

When to use	Suspected or Confirmed Case
Responsible	IPC lead or designate
Source	https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/routine-practices-additional-precautions/additional-precautions-signage



11.2.7 EDUCATION MATERIALS: HIGH TOUCH SURFACES

When to use	Suspected or Confirmed Case
Responsible	IPC lead or Environmental Manager
Source	https://www.publichealthontario.ca/-/media/documents/B/2018/bp-environmental-cleaning.pdf (p.64)

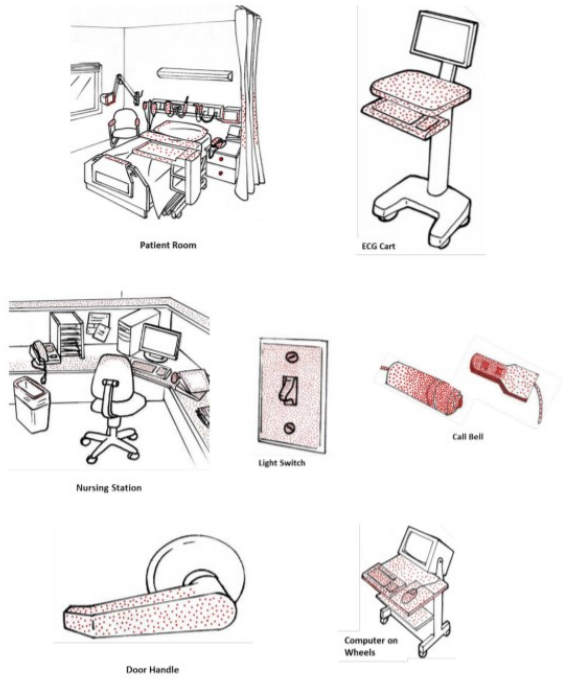


Figure 3a: Examples of High-Touch Items and Surfaces in the Health Care Environment
(Note: Dots indicate areas of highest contamination and touch)

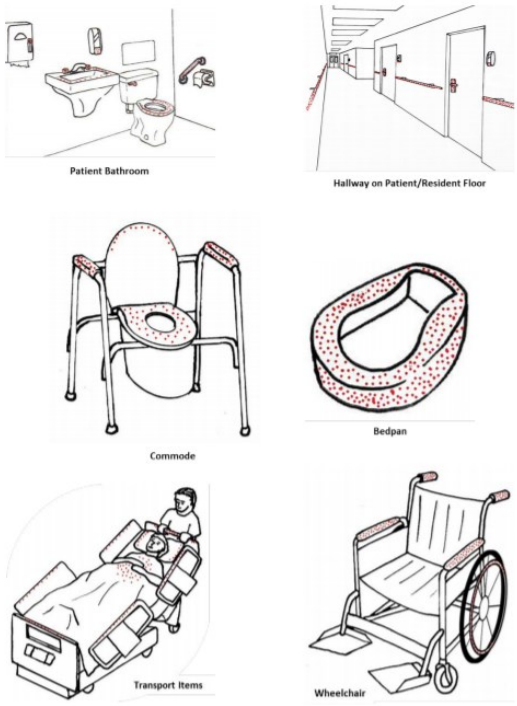
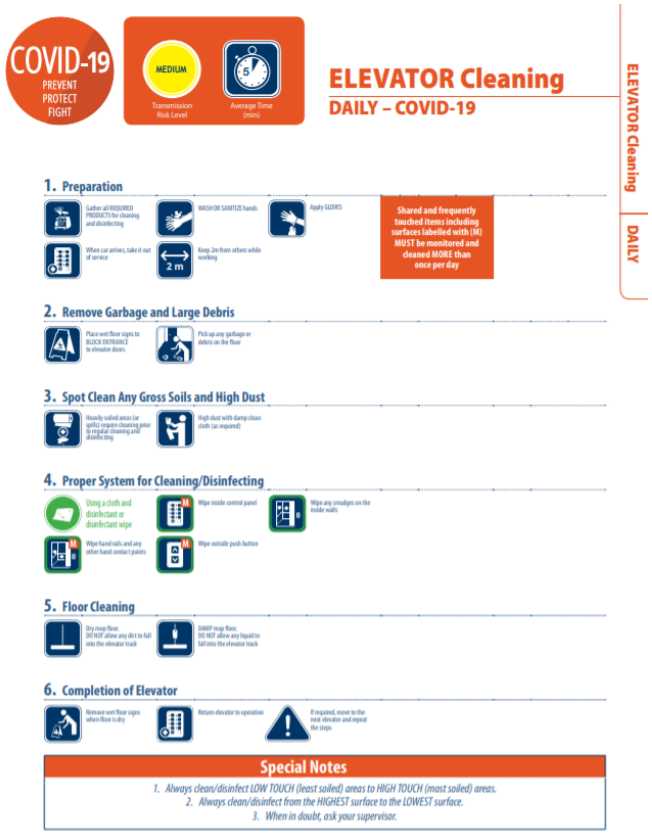
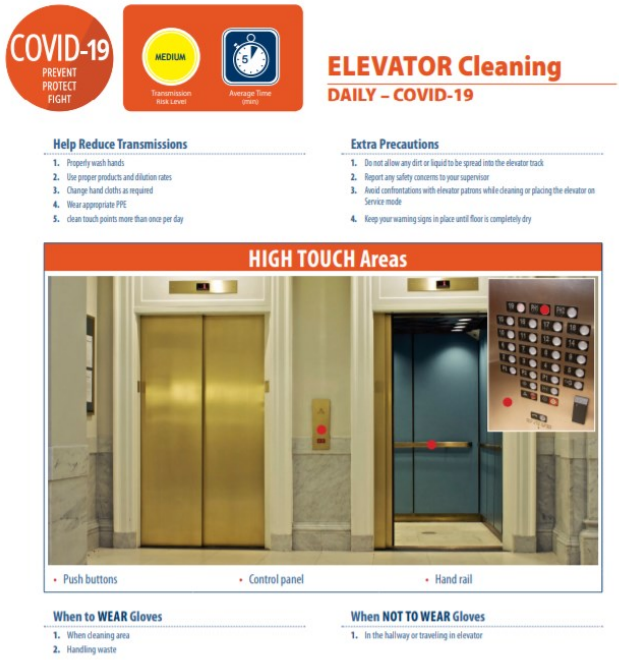


Figure 3b: Examples of High-Touch Items and Surfaces in the Health Care Environment
(Note: Dots indicate areas of highest contamination and touch)

11.2.8 EDUCATION MATERIALS: ELEVATOR CLEANING

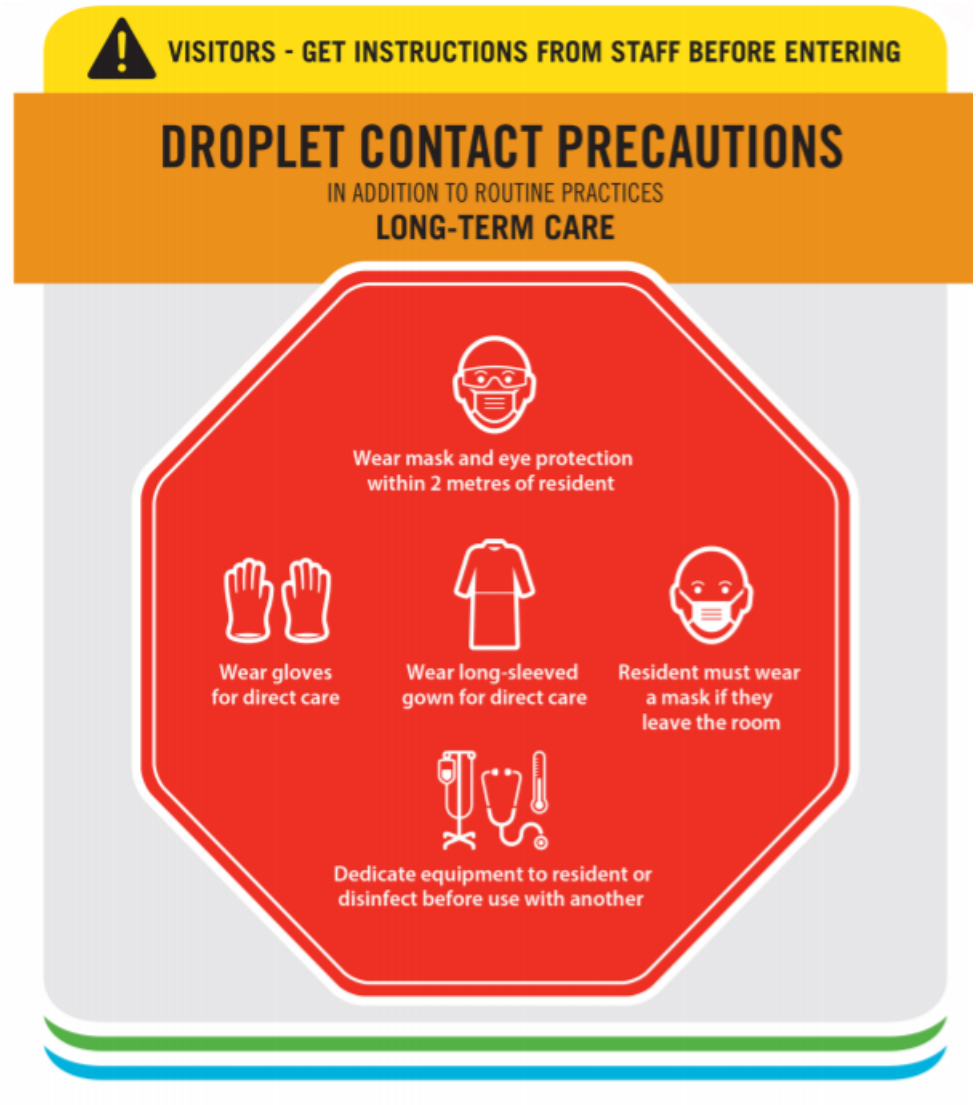
When to use	Suspected or Confirmed Case
Responsible	IPC lead or Environmental Manager
Source	http://www.sanimarc.com/wp-content/uploads/2020/05/General_Elevator_Cleaning_Daily_en.pdf





11.2.9 SIGNAGE: ROOM SIGNAGE FOR DROPLET AND CONTACT PRECAUTIONS

When to use	Suspected or Confirmed Case
Responsible	IPC lead or designate
Source	https://www.publichealthontario.ca/-/media/documents/s/2013/sign-ltc-stop-droplet-contact.pdf?la=en



11.2.10 SIGNAGE: PPE DONNING AND DOFFING

When to use	Prevention (Education purposes), Suspected or Confirmed Case
Responsible	IPC lead or designate
Source	https://www.publichealthontario.ca/-/media/documents/l/2013/lanyard-removing-putting-on-ppe.pdf?la=en

11.2.11 SIGNAGE: ROUTINE PRACTICES

When to use	Suspected or Confirmed Case
Responsible	IPC lead or designate
Source	https://www.publichealthontario.ca/-/media/documents/b/2012/bp-rpap-healthcare-settings.pdf?la=en

ROUTINE PRACTICES to be used with ALL PATIENTS	
	**Hand Hygiene** Hand hygiene is performed using alcohol-based hand rub or soap and water: ✓ Before and after each client/patient/resident contact ✓ Before performing invasive procedures ✓ Before preparing, handling, serving or eating food ✓ After care involving body fluids and before moving to another activity ✓ Before putting on and after taking off gloves and PPE ✓ After personal body functions (e.g., blowing one's nose) ✓ Whenever hands come into contact with secretions, excretions, blood and body fluids ✓ After contact with items in the client/patient/resident's environment
	**Mask and Eye Protection or Face Shield [based on risk assessment]** ✓ Protect eyes, nose and mouth during procedures and care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions. ✓ Wear within two metres of a coughing client/patient/resident.
	**Gown [based on risk assessment]** ✓ Wear a long-sleeved gown if contamination of skin or clothing is anticipated.
	**Gloves [based on risk assessment]** ✓ Wear gloves when there is a risk of hand contact with blood, body fluids, secretions, excretions, non-intact skin, mucous membranes or contaminated surfaces or objects. ✓ Wearing gloves is NOT a substitute for hand hygiene. ✓ Remove immediately after use and perform hand hygiene after removing gloves.
	**Environment and Equipment** ✓ All equipment that is being used by more than one client/patient/resident must be cleaned between clients/patients/residents. ✓ All high-touch surfaces in the client/patient/resident's room must be cleaned daily.
	**Linen and Waste** ✓ Handle soiled linen and waste carefully to prevent personal contamination and transfer to other clients/patients/residents.
	**Sharps Injury Prevention** ✓ NEVER RECAP USED NEEDLES. ✓ Place sharps in sharps containers. ✓ Prevent injuries from needles, scalpels and other sharp devices. ✓ Where possible, use safety-engineered medical devices.
	**Patient Placement/Accommodation** ✓ Use a single room for a client/patient/resident who contaminates the environment. ✓ Perform hand hygiene on leaving the room.

		Prevention & Preparedness	Suspected Case				Test		Outbreak		
		Ongoing	Initial		Ongoing	End	Initial	End	Initial	Ongoing	End
Category	Who is informed		Immediate	Within 24 hours					Immediate		
Internal	Home Management	Yes (weekly)[1]	Yes		Yes (daily, tracking increase in cases)	Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	Outbreak Management Team (OMT)	Yes (weekly)[1]	Yes		Yes (daily)	Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	Infection Control Lead(s)	Yes (weekly)[1]	Yes		Yes (daily)	Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	Joint Health & Safety Committee	Yes (as required)	Yes			Yes	Yes	Yes	Yes	Yes (daily or even twice a day)	Yes
	All affected residents and families	Yes (weekly)[2]	Yes (by home area)		Yes (daily)	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	All non-affected residents and families	Yes (weekly / as required)	At discretion of management		Yes (weekly)	Yes	Yes	Yes	Yes	Yes (2-3 times a week)[5]	Yes
	All home employees	Yes (weekly / as requried)[3]	Yes		Yes (daily)	Yes	Yes	Yes	Yes	Yes (q shift)	Yes
	Regional Leaders / HQ / Board (if applicable)	Yes (weekly reports, template)	Yes		Yes (weekly / bi-weekly[5])	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	Home Medical Director / Physician		Yes		Yes (weekly)	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	Home Line Listing: Resdient		Yes		Yes (weekly)	Yes	Yes	Yes	Yes	Yes (q shift)	Yes
	Home Line Listing: Employee		Yes			Yes	Yes	Yes	Yes	Yes (q shift)	
	Signage (Room / Unit / Building)	Yes (selective[4])							Yes		Yes
External	Pharmacy		Yes			Yes			Yes		Yes
	Laboratory			Yes		Yes			Yes		
	Other suppliers / contractors			Yes (change delivery mode)		Yes			Yes		Yes
	Agency support (if applicable)						(depends on survey)	(depends on survey)	Yes		Yes
	Volunteers						(depends on survey)	(depends on survey)	Yes		Yes
Autho-rities	Local Public Health	Yes (w as required e.g. for eventual questions)	Yes (request swabs)		Yes (every second day / weekly[5]	Yes	Yes	Yes	Yes (PHU makes the announcement)	Yes (daily)	Yes
	Municipal / City Authorities		Yes (tbd)		Yes (twice a week)[7]	Yes	Yes	Yes	Yes	Yes (daily)	Yes
	Director for the LTC Ministry / MOH				Yes (weekly)[8]				Yes		Yes
	Hospital Emergency Department / Paramedics						Yes	Yes	For all transfers including prior ones		Yes
	LHIN						Yes	Yes	Yes		Yes
	Union(s) representatives		Yes			Yes	Yes	Yes	Yes		Yes
	Ministry of Labour (if employee(s) affected)		Yes			Yes			Yes		Yes

1 - Weekly meeting with all departments, e.g. budget, EHR minutes, Whats - TELUS app
2 - updated e.g. what we do re PPE, etc
3 - Depends on tech available for employees, e.g. via Whatsup - push communication
4 - Selective e.g. temperature, disancing, travellers as applicable
5 - Depends on available resources for communication
6 - The more communication, the better
7 - Suspected case communications as operational meetings with city 2x / week - need to notify in cases of resident isolation or staff off
8 - Weekly communications with MOH inspector to advise on status

11.3.2 REGULAR STAFF UPDATE SAMPLE

Good afternoon,

HAPPY MOTHER'S DAY!
Underneath each and everyone's personal life stories, lies our mother's story…because her story is where our own story began. On behalf of the management team, the [redacted] and I, we would like to take a few moments to wish all the mothers out there a wonderful day! ●

COVID-19 TEST RESULTS

If you would like to view your COVID-19 test results, please visit the following website.

https://covid19results.ehealthontario.ca:4443/agree

You will need your health card handy to check your results.

When they ask you for your stock control number #, it's the numbers at the back of your card. It will have 2 letters and 7 numbers. (ex: TN1234567)

Under your first name, you have to enter all the first names indicated on your health card.

For example: If the name on the card is John Michael Freeman, you would need to enter: John Michael as your first name and Freeman as your last name.

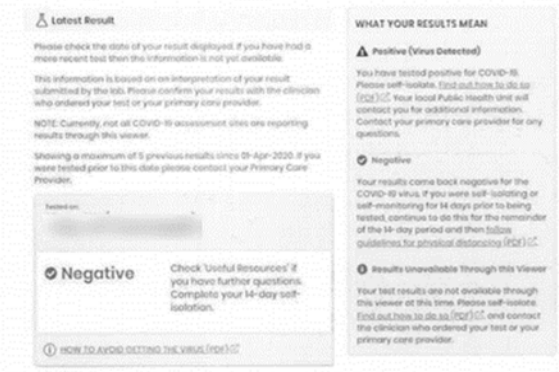
The postal code is your home address postal code. (wherever your health card renewal form is sent to).

IF your result is negative, please print/scan and email me a copy. You can also send me a screenshot as long as I can see your name on top along with the result.

IF your result is positive, you must **immediately self isolate and call the charge nurse at** [redacted]

IF you do not have any results yet, please wait another day. If you still do not have any results by Monday night, please let us know.

Your test results will look like this:



OTHER HOMES IN OUTBREAK

I would like to provide some suggestions/recommendations on what to do in an event that another home is in outbreak and your significant other works at that home.

1- If your significant other doesn't have any symptoms, was tested, is negative, and you don't have any symptoms, you are able to come to work;
2- If your significant other has symptoms, was tested and is positive, you must self isolate, notify us and call the health unit;
3- If possible/feasible, I would encourage you to stay in different areas of your home, each of you have your dedicated washroom, own linen set, separate bedroom and keep physical distancing as much as possible. If you only have 1 washroom, ensure to disinfect it after each use.
4- I would recommend that the person that does not present any symptoms cook and do daily chores around the house to minimize the risk of cross contamination/exposure
5- I would encourage you to take a shower at home before and after work.
6- I would encourage that the employee who is not affected by the outbreak be the one that does household errands.
7- If both of you need to self isolate, please ask a friend to do your groceries/errands for you.
8- If you are asked to self isolate, you should be staying at home and not be taking daily walks around the block or drive around the city.
9- I would encourage you to only do grocery shopping 1x/week or every 2 weeks if this is possible.

These are solely precautionary recommendations that I am suggesting to you to ensure that your co-workers are safe and for us to do our best to keep our residents and our families healthy and safe. If you have any best practices that you have implemented at home and would like to share them with us, please email me and I would gladly share the information with others.

NURSES WEEK (MAY 11 – 17, 2020)
This week is Nurses week! The theme this year is **NURSES: A VOICE TO LEAD – NURSING THE WORLD TO HEALTH**. The theme was developed by the International Council of Nurses (ICN) to showcase how nurses are central to addressing a wide range of health challenges. ICN says the theme will help raise the profile of the profession and attract a new generation into the nursing family.

The World Health Organization (WHO) has designated 2020 as the Year of the Nurse and Midwife in honour of the 200th anniversary of Florence Nightingale's birth.
- Learn more at: https://www.cna-aiic.ca/en/news-room/events/national-nursing-week#sthash.8OQdHLNq.dpuf

Due to COVID, we will be postponing the annual events that are usually held [redacted] until COVID is done and it is safe to socialize. We will be drawing gift cards during the week to recognize our health care workers instead.

QUOTE OF THE DAY
"I am only one, but I am one. I cannot do everything, but I can do something. And I will not let what I cannot do interfere with what I can do."- Edward Everett Hale

FINAL REMARKS

Thanks again for the wonderful work you all do day in, and day out. Thank you for working so hard every day to lift the resident's spirits and keeping things feeling like a home, even though they are not able to have their loved one visit.

Until next time, Stay well and healthy!

Regards,

11.3.3 STAFF NOTIFICATION OF OUTBREAK

[Home Logo]

[Date]

Dear **[Home Name]** Team,

I am writing to inform you that we received confirmation today from **[regional public health unit]** that that one of our **[residents/team members]** has tested positive for COVID-19. The **[current state of resident or team member – self-isolating, transferred to hospital, etc.]**

I understand that this may not be easy to hear, but rest assured, everyone is doing an outstanding job and I am confident that our highly trained team will get through this challenging time.

We are working diligently with public health, who have confirmed that the following additional measures be put in place immediately:

[List of COVID-19 related measures based on CMOH Directive dated April 15, 2020]

- New resident admissions are not allowed until the outbreak is over.
- No re-admissions of residents until the outbreak is over.
- If residents are taken by family out of the home, they may not be re-admitted until the outbreak is over.
- For residents that leave the home for an out-patient visit, the home must provide a mask and the resident, if tolerate, wear a mask while out and screened upon their return.
- Discontinue all non-essential activities.
- Team members will actively screen each resident twice daily, including temperature checks.
- All essential visitors and staff entering the home will be actively screened, including temperature checks.
- Testing will be conducted for COVID-19 on all symptomatic residents and staff in the community.
- Staff who have tested positive and symptomatic will not attend work.

If you have any questions or concerns, please reach out to me at **[email address]** and I would be happy to speak with you. I will continue to update the team as new information becomes available in the coming days.

Thank you so much for continuing to provide our residents with the outstanding care they deserve during this difficult time. You are an exceptional team, and we truly appreciate each and every one of you. We are all in this together.

Sincerely,

[Name]
[Title]
[Home Name]

11.3.4 LETTER TO FAMILIES: DAILY UPDATE

[redacted] 2020 Current Status 7:30pm

On LTC, with our latest rounds of re-testing the results have been mixed. We have identified that several symptomatic residents were indeed positive as expected. There are also a good number that returned negative. All covid positive residents have been and continue to be isolated into cohorted care groups.

There are two bright spots however. We have our first resident listed as "resolved" [redacted]. We also have another [redacted] residents that have been re-swabbed and are way past the 14 day mark with no symptoms. We are hoping that they also resolve. That will be cause to celebrate!

Retirement is continuing to re-swab until the covid cases show two negative results. Many of these have been a long time without symptoms so again we wait for resolved. We have no new cases and no new symptoms there.

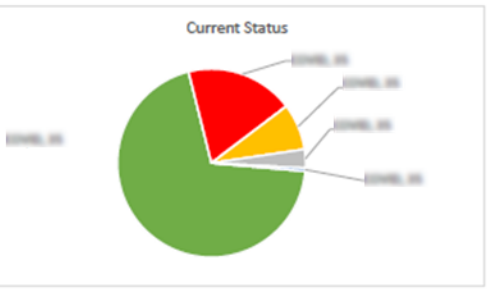
We are ramping up our disinfecting practices across [redacted] as an extra layer of defense, well above protocol. In this unknown virus we don't want to leave any possibility. Even with all of our extraordinary efforts, this has continued to spread. I promise you that we have been doing everything in our power to fight it. We are swimming upstream but are so grateful for the support of our family members every day.

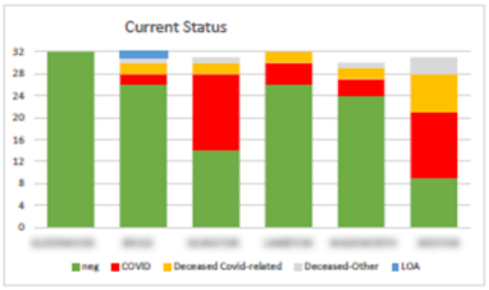
RETIREMENT	Current In House Positive cases	Current Negative Cases	COVID19 Deaths	Resolved
[redacted]				

LTC	Current In House Positive cases	Current Negative Cases	COVID19 Deaths	Resolved
[redacted]				

[redacted]

Count of Resident	Column Labels					
Row Labels	neg	COVID	Deceased Covid-related	Deceased-Other	LOA	Grand Total
[redacted]						





11.3.5 WEBSITE CASE COUNT

https://schlegelvillages.com/news/precautionary-measures-response-covid-19

24-May-20	# of Resident Capacity at the Village	Neighbourhood	Net Change in Confirmed Resident Cases in the Past 24 hours	Deaths in the past 24 hours who had tested COVID positive	Total Current Confirmed Resident Cases	Total Deaths of Residents who had tested COVID positive	Net Change in Confirmed Team Member Cases in the Past 24 hours	Total Current Confirmed Team Member Cases	Total Confirmed Negative Swabs Received From Public Health
The Village of Erin Meadows Long Term Care	180	Meadowvale	0	0	3	8	0	4	Reswabbed 129 residents & 111 team members
		Derry	0	0	6	7	1 resolved	1	
		Dundas	0	0	0	4	0	4	
		Howland	0	0	0	1	0	2	
		Non-neighbourhood Specific	N/A	N/A	N/A	N/A	0	4	
Erin Mills Lodge Long Term Care	86	Sheridan Way	0	0	0	6	0	12	48 residents
		Erindale place	1 correction	0	1	6	0	9	
		Hazel Lane	0	0	16	5	0	17	
		Non-neighbourhood Specific	N/A	N/A	N/A	N/A	0	4	
The Village of Humber Heights Retirement	250	Emma's	0	0	11	9	0	3	114 residents
		Egerton	0	0	0	1	0	0	
		Williamsburg	0	0	13	5	0	1	
		Becker	0	0	1	1	0	1	
		Non-neighbourhood Specific	N/A	N/A	N/A	N/A	0	3	
The Village of Humber Heights Long Term Care	192	Lambton	0	0	3	2	0	1	143 residents & 41 team members
		Weston	0	0	10	7	0	8	
		Brule	0	0	8	2	0	2	
		Wadsworth	0	0	3	2	0	0	
		Alderwood	0	0	6	0	0	2	
		Islington	0	0	11	5	0	3	
		Non-neighbourhood Specific	N/A	N/A	N/A	N/A	0	2	
Maynard Long Term Care	77	Trinity	0	0	0	0	0	1	77 residents (all) & 55 team members
The Village of Winston Park Long Term Care	95	Trussler	1 resolved	0	0	0	0	0	88 residents & 110 team members
The Village of Taunton Mills Long Term Care	120	Claremont	0	0	0	0	0	1	109 residents & 129 team members
		Non-neighbourhood Specific	0	0	0	0	0	1	

11.3.6 LETTER TO FAMILIES: POSITIVE RESULTS

April 26, 2020

To: All [HOME] Residents, Families and Substitute Decision Makers

Re: COVID-19 Update #[#]

As you are aware, as a proactive measure, [##] [residents/staff] at [HOME] were tested last week for COVID-19.

We are writing to inform you that we have received confirmation of positive test results. Currently, [#] residents and [#] staff members have tested positive for COVID-19. Ministry of Health direction requires a COVID-19 outbreak be declared with a single laboratory-confirmed case in a resident or staff member.

The residents with positive test results are now on isolation with droplet precautions in private rooms in [#] Home areas with dedicated staff wearing personal protective equipment (PPE) for all resident interactions. All staff members caring for residents in these Home areas are not performing work outside of this area, wherever possible. Further, all meals for impacted Home Areas will be served in the resident rooms.

With regards to staff members who have tested positive for COVID-19, all have been notified and are at home self-isolating. They will not be returning to work until they have self-isolated for 14 days.
All residents and staff members with positive test results are asymptomatic and doing well. Additional measures have been implemented as part of our pandemic plan, in line with the Chief Medical Officer of Health and the Ministry of Long-Term Care directives. We continue to work closely with Public Health to ensure every possible step is being taken to protect our residents and staff members.

We understand that this is extremely difficult news to hear, and will certainly be concerning for residents, families and caregivers. We want to reiterate that the health, safety and well-being of your family members and our staff are our highest priority, and the risk of COVID-19 spreading in the Home remains low.

We have taken swift actions to stop the potential spread of the virus through rigorous infection management practices and protocols. Our staff are highly trained and experienced with respiratory illness outbreaks, and we are confident in their abilities to manage this situation.

Of the [#] residents and [#] staff that have been tested, [#]% of the test results are negative. We expect further results over the next few days. We will continue to keep you informed through phone calls and letters and updates will also be posted on our website at [www.website.com]. Should you have any questions, please do not hesitate to contact us at [email@email.com].

The care and safety of residents and staff is always our No. 1 priority.
Sincerely,
[Administrator]