Long-Term Care Emergency preparedness checklist – 2022

Introduction

Under s. 269 (1) of O. Reg. 246/22, emergency plans for communicable diseases, diseases of public health significance, epidemics, and pandemics, each home should have a comprehensive IPAC Program, which includes specific IPAC policies & procedures, cohorting plans for residents and staffs. This checklist may be used to generate/ collate or organize your emergency plans as required in the Long-Term Care emergency preparedness manual.

Hazard Identification and Risk Assessment (HIRA) for Infectious Disease: Please attach a completed HIRA framework along with the checklist https://www.publichealthontario.ca/-/media/documents/h/2020/hira-worksheet-template.pdf?sc_lang=en

	ASSESSMENT CRITERIA FOR EMERGENCY PREPAREDNESS	**COMMENTS (explain current practices in place)**	**EVIDENCE**
A) *OUTBREAK REPORTING/ COMMUNICATION* Long-term care homes are required to have access to reliable communication equipment in case of an emergency:			
	1. Up-to-date policies and procedures for identifying and reporting outbreaks	Annual review of IPAC policies	Ongoing process
	2. Are the frontline staff aware of whom to report to in case of a new or suspected outbreak?	Yes	Policy #13.08
	3. Accessible communication channel in an outbreak like Landline, walkie-talkie	Portable phones, Landline, E-mails, walkie-talkie Phone number available in Policy# 13.08	Policy# 13.08
B) *FOOD, FLUID, AND DRUG PROVISION* - Accessing resources may be impacted in an emergency, to limit supply issues, in accordance with the best practices of Infection Prevention and Control, homes are encouraged to think critically about their resource stockpiles. In an event of shortage:			
	4. Co-ordinate with volunteer services and/or an Ontario Health Team in bringing in pre-prepared meal service	Refer to Emergency plan for dietary services	Emergency plan for dietary services
	5. Label all equipment and attach laminated instruction cards on how to use, retrieve and/or move each assistive device during an emergency	Refer to emergency plan for dietary services	Emergency plan for dietary services

	6. Sanitizing med- cart, labeling, keeping away personal items from public spaces to prevent cross-contamination	Ongoing process practice with regular monthly random audits	Audits
C) SUPPLIES AND RESOURCES Review your inventory of supplies and expiry dates as applicable. In case of emergency preparedness with outbreaks consider:			
	7. Assessment of each resident's resource needs	-List of residents on resource 'and supplements -List of inventories of supplies for 7 days -Back up Emergency briefs supplies, located on the 2nd floor North side Coombs -Available brief list with resident's name and size, updated monthly - Medication plan back-up- Pharmacy	Please refer to Dietary emergency plan Continence Care list Pharmacy Disaster Plan Supplies policy #3.12
	8. An estimate of short-term resources that must be available immediately	Variety of resources and supplements are available for minimum 7 days in the s available on 2nd floor N side Coombs storage room, MM and MRR fridges -Briefs all sizes located on the 2nd floor North side Coombs -Food enough to cover the first 3 days. -PPE emergency supplies, Gowns, gloves, face shields, surgical masks, N95 to cover at least two weeks supply	Dietary emergency plan Continence Care list PPE Pandemic supply room on Fisher, 3rd floor
	9. Location of stockpiles and expiry	Emergency outbreak supplies PPE kept in the Pandemic room in Fisher on the 3rd floor (IPAC Coordinator)	List includes numbers and expiry dates
D) LINE OF COMMAND/ LEAD Who is the key personnel member with the authority to complete a particular task (e.g., declaring an emergency) in case of an emergency***?***			
	10. Lead for Information sharing within the LTCH, with external partners, media coverage, and communicating with family.	E.D/Designate DOC ADOC IPAC lead	Policy # And 13.05 Communication of Outbreak
	11. Communication plans the facility has in case of emergency	Communicate with North Toronto IPAC team -HUB team DR. Chan and Dr. Leis -TPH- (collaborate and receive direction) -Communication with IPAC lead, DOC and E.D	Policy #13.34 And policy #13.36

		-Communicate with families via e-mails and phone calls, -Nurse designates will be calling the family members. ED/Designate will send written communication to all family members, staff, external partners -Communicate the outbreak plan with the charge nurses who will inform residents. -Refer to emergency plan for dietary services; communicate and present finding to CQI committee	Mailchimp emails to all family members, staff, external partners
E) STAFF ROLES AND RESPONSIBILITIES To ensure a smooth rollout of emergency plans, it is mandatory to develop staff roles and responsibilities for emergencies. This includes:			
	12. Review the essential services list to identify who is best to complete these roles and backups to core roles	Essential services 1-Dietary services- Food Services Manager 2-Enviromental Services – ES Manager 3-Nursing Services-DOC 4-Management and communication services- Executive Director 5-Staffing -Scheduling and staffing coordinator 6-Nursing Supplies - ADOC 7-Diagnostic Services- QI Coordinator	Please refer to updated list in emergency plan binder
	13. Staff assignments for core functions	-Registered staff -PSW staff -Dietary staff -Cooks -Environmental staff -Recreation staff -Programs Leads (IPAC, BSO, CQI)	Please see policy #13.60 Page 3,4,5,6
	14. Roles and responsibilities need to be prioritized in an event of staffing shortage where services are limited to core functions	Meighen Manor staffing plan	Policy 13.60
F) SURVEILLANCE Facilities should have a surveillance program in place for early detection of infectious agents in their residents to trace patterns of spread that may indicate a possible outbreak, Consider:			

	15. Active and passive screening process in place for all persons entering the home - e.g., staff, visitors, students, volunteers, residents returning	Home is following the latest directions by Ministry of Long-Term Care and Public Health. Currently: Daily active screening process in place for everyone entering the facility exempt emergency personal. -including daily RAT, waiting period of 15 min in the designated waiting area before going into units. – If staff tested positive on RAT, will have PCR done, obtain information for the Contact tracing form, sent home with instruction of isolation. If PCR positive, remain home x10 days. Resident going on LOA less than 24 hrs, will be on observation x 5 days, RAT or PCR on day 5, no need for isolation.	
	16. Staff awareness on initiating additional precautions immediately based on surveillance screening	Following the Public Health direction, upon starting resident observation and surveillance, staff are educated and aware of isolating resident with one symptom, staff will place resident in isolation on DCP, PCR will be obtained, signage and necessary PPE (mask, gloves, gown and face shields) at the entrance to resident's room including hamper with yellow bag and waste management bin.	
	17. Are there surveillance tools in place to identify and track enteric or other respiratory illnesses to identify outbreaks - e.g., completing active line lists, daily unit checks, internal tools for monitoring illness	Daily symptoms surveillance tool in each unit, each charge nurse for every shift is responsible to fill up the form, if no cases, will keep the form blank; Night RN/RPN staff submits sheet to IPAC lead via folder at reception every morning including weekends. In case of outbreak, daily line list will be initiated and submitted based on PH direction.	
	18. Discussing abnormal surveillance findings at IPAC meetings	Every morning at the staff meeting with the DOC and ADOC, the IPAC lead will discuss the abnormal surveillance finding, residents on isolation or antibiotics therapy and/ or other infections.	

G) COHORTING

Cohorting is one of many layers of protection or control measures available to prevent the spread of infection within the facility, by grouping residents based on their infectious status or risk during an outbreak and assigning staff accordingly.

	19. Designated area exclusively for isolating residents - E.g., separate room, dining area, activity room designated for cohorting	At the IAMM there are 144 single rooms, each resident with symptoms will be isolated to his own room; 24 rooms share a bathroom; in this case, the resident on isolation will be provided with the commode, and the other resident will be using the bathroom. North side of each unit can be further isolated from South and vice versa by closing the fire separation doors Activity room in outbreak unit will be used as a break room for staff as part of cohorting staff. As per TPH and the HUB direction, tray services will be provided for the residents if decided on keeping all residents in their rooms, or non symptomatic resident could have their meals in the dining room; another option is staggered dinning	
	20. Assigning staff and residents into Units divided into "outbreak side / non-outbreak side" with dedicated staff/equipment and utilities and a cohort plan when working with staff shortage, (e.g., designated staff to work in specific areas, or care done in sequential fashion – negative residents first then suspected/ confirmed cases)	Home will try to cohort staff to the specific unit on outbreak although sometimes staff shortage will make it challenging, but a cohort plan when working with staff shortage is in place: – Negative residents care will be provided first, then suspected as the second group and at last, for confirmed cases.	
	21. Having staff contingency plans to ensure continuity of care (e.g., additional support plans like central emailing to staff, external staffing support, job guidelines for external staff, delegating authority in the absence of key individuals, maintaining an emergency contact log of all staff/ sister facilities, number of staffs required during normal vs minimum number of staffs needed during the crisis	The outbreak plan includes staff responsibilities, and reporting protocols based on the Health Protection and Promotion Act, written communication and protocols for receiving and responding to health alerts. The MHC outbreak plan will be implemented as expeditiously as possible to interrupt further transmission of illness, and support a safe and therapeutic environment for residents, staff, and visitors. All components listed below will be utilized during the Outbreak Contingency Plan. Toronto Public Health Respiratory and Enteric outbreak directions will be followed such as detailed guidelines of the outbreak contingency plan: • Outbreak recognition procedure/ Case definition	Policy# 13.34

		• The Outbreak Team • Information tools and communication systems • Notification procedure • Control Measures • Investigation • Specimen collection • On-going Surveillance • Education • Staffing issues • Post-Outbreak follow-up	
	22. Business continuity plan (e.g., Policies for potential staff shortage, redeployment plans)	Yes	Policy #13.60
	23. Maintaining policies to manage staff who may be exposed to infectious disease (Routine practices, policies on prompt reporting-OHS, post-exposure-assessment- treatment- and monitoring, health, and safety education programs, and counseling for staff regarding the occupational risk from infectious agents, guidelines for work restrictions, clearance for fitness to work, immunization policies in place)	Please refer to IPAC and OHS policies	Need policies
	24. Managing symptomatic residents and staff (Routine practices/hand hygiene, policies for implementing additional precautions, performing risk assessment before the patient visit, communicating resident/staff communicable disease symptoms, initiating isolation)	Symptomatic residents will be in isolation / DCP -Continued assessment including vital signs/q shift -All necessary isolation items at the entrance to residents' room -Additional precaution will be added to routine practices/ hand hygiene as per 4 moments. -Point of care risk assessment before entering the resident's room. Communicate any residents/staff with communicable disease to TPH/Hub, send staff home immediately	Need policies
	25. Outbreak Management Team and their roles, (e.g., public health, outbreak lead,	OMT members:	Policy # 13.36

	administrators, managers, environmental lead, IPAC lead, frontline lead, communication lead)	• Infection Control Coordinator -surveillance and data collection, communicate with TPH and HUB (North Toronto IPAC team), inventory and control of PPE emergency supplies. • A Public Health Department representative • North Toronto IPAC team • Director of Care- Support OMT team, communication with families via emails- ensure the care needs of residents in outbreak unit • Assistant Director of Care and QI Coordinator- Provide support to the units • Executive Director -communicate with THQ • Medical Director -Provide medical assessment and orders as needed. • Environmental Services Manager- control heating and cooling, monitors cleaning and disinfection • Food Services Manager- inventory of supplies, resources • Chaplains – provide emotional support to families, residents and staff • Nurse Designate- provide support to the units, cover for the unit as a charge nurse as needed. If available inform families via phone. Human Resources- provide Memo to staff Responsibilities of the OMT • Meet within 24 hours of notifying the TPH of a suspected outbreak. • Conduct follow-up meetings as needed. • Delegate various aspects and components of an Outbreak Plan and determine responsibilities for follow-up. • Record decisions made • Co-ordinate information, direction and protocols from TPH representative or designate. • Recommend appropriate action to control and contain spread of infection over and above established control measures	

		• Review and revise aspects of the Outbreak Plan as needed • Collaborate and receive direction from TPH in the investigation process • Communicate Outbreak Plan to internal and external stakeholders • Determine who will speak with the media, if required- ED/Designate • Produce a final report • Present findings to the CQI Committee.	
H) VACCINATION/ MEDICAL PREPARATION			
	26. Tracking and maintaining up-to-date information on the vaccination status of staff and residents	Residents' vaccination information recorded and documented in each resident's profile in PCC under immunization tab. As well there is a COVID list spread sheet, with information of resident's COVID vaccination in J-Drive under COVID - resident's vaccination. H. R department maintains updated staff immunization list. Also, the information regarding staff influenza vaccines can be found under J-drive -infection control-vaccine	
	27. Policies and procedures on education regarding staff exclusion, including refusal of immunization and/or refusal of medication in the event of an outbreak	The Ministry of Long-Term Care directives or TPH directions will be followed.	HR policy and Collective agreements
I) PLAN TO RECOVERY Channels may be intimidating for some staff and residents, so providing opportunities for informal discussion may be helpful in hearing all individuals and developing plans that reflect their concerns			
	28. Huddles/ reflective discussions	Outbreak declaration summary meeting will be held at the management level in coordination with TPH, the HUB, and the lessons learned will be discussed with all the staff.	

Resources

https://www.health.state.mn.us/communities/ep/ltc/ltccstemplate.docx

https://www.rhra.ca/wp-content/uploads/2020/12/ORCA-COVID-19-Staffing-Contingency-Plan-Guide-November-2020-update.pdf

https://www.oha.com/labour-relations-and-human-resources/health-and-safety/communicable-diseases-surveillance-protocols

https://www.publichealthontario.ca/-/media/Documents/B/2012/bp-rpap-healthcare-settings.pdf?sc_lang=en

https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/05/managing-covid-19-outbreaks-congregate-living-settings.pdf?la=en

Diseases of Public Health Significance Cases for January to December 2021 (publichealthontario.ca)