Provincial
Long Term Care/Personal Care Home
Pandemic Plan

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Section I

Provincial Long-Term Care/Personal Care Home Pandemic Plan

Introduction

Building on the learnings of the COVID-19 pandemic outbreak across multiple Personal Care Homes, this provincial pandemic plan will serve as a guide to assist with future pandemics that may be experienced within the province of Manitoba. This plan will be implemented upon the direction of the Chief Provincial Public Health Officer and will be revised, altered and changed as directed by the Chief Provincial Public Health Officer and will adhere to Infection Prevention and Control standards.

There exists confusion between the language of epidemic, pandemic and outbreak therefore it is important to understand their meanings to prevent confusion in planning.

- An outbreak is "a sudden rise in the incidence of a disease" and typically is confined to a localized area or a specific group of people. Should an outbreak become more severe, and less localized, it may be characterized as an epidemic. If it broadens still further, and affects a significant portion of the population, the disease may be characterized as a pandemic.

- An epidemic is an outbreak of disease that spreads quickly and affects many individuals at the same time.

- A pandemic is a worldwide spread of a new infectious disease: one which has spread across a wider geographic range than an epidemic, and which has affected a significant portion of the population.

A Pandemic occurs when an organism, to which most humans have little or no immunity, acquires the ability to cause sustained human-to-human transmission that leads to a rapid worldwide spread. The organism may arise through genetic re-assortment (animal and human influenza genes mix) or genetic mutation (when genes in an animal virus change), allowing the virus to easily infect humans. When exposed to the new organism, most people will become ill, as they have no immunity to the newly mutated strain. If the new organism causes severe disease, it can lead to a significant number of hospitalizations and deaths causing social and economic disruption. Pandemics can last anywhere from 12 to 18 months.

Early recognition and prompt reporting in response to unusual clusters of illness are essential for effective management of outbreaks. When appropriate infection prevention and control measures are implemented in a timely manner, outbreaks are generally controlled quickly. For more detailed information about outbreak management, please consult your Infection Control Professional (ICP). In the event of an outbreak or threat of an outbreak of unusual infectious disease, such as a newly emerging respiratory/novel influenza virus or any other infrequent infectious disease, direction for

outbreak management of emerging pathogens will be provided by Public Health (PH), Infection Prevention and Control (IP&C), Medical Officer of Health (MOH), Occupational and Environmental Safety and Health (OESH) and will extend beyond this document.

Purpose

This plan has been designed to provide direction in pandemic planning and outbreak response preparedness, to improve the capacity to respond to a potential and actual outbreak of an evolving organism.   Each SDO is responsible for the creation of a pandemic response governance structure which includes PCH operators that supports an overall pandemic unified incident management system.

Provincial Service Delivery Organizations (SDO) and Personal Care Homes (PCH) will use the provincial pandemic plan to develop site working documents to ensure that they have a pandemic plan in the future that will support resident care and prepare staff to maintain a safe, healthy and caring environment during an outbreak.

Definition/Acronyms

CED   Communications and Engagement Division Manitoba (formerly Communications Services Manitoba)
DFC   Designated Family Caregiver
ICP   Infection Control Professional
IP&C   Infection Prevention & Control
MOH   Medical Officer of Health
NP   Nurse Practitioner
OESH   Occupational and Environmental Safety and Health
PCH   Personal Care Home
PH   Public Health
PPE   Personal Protective Equipment
POA   Power of Attorney – is the legal authority contained in a written document that allows someone else to manage a person's legal and financial affairs.
RHA   Regional Health Authority
SDM   Substitute Decision Maker*
SDO   Service Delivery Organization
TCC   Transitional Care Centre

*Substitute decision maker has been used throughout this document to refer to the following legal representatives (a) **a proxy** appointed by a resident under The Health Care Directives Act, to the extent of the proxy's powers under the health care directive; (b) **a committee** appointed for a resident under The Mental Health Act, to the extent of the committee's powers under the appointment; (c) a **substitute decision maker** for personal care appointed for a resident under The Vulnerable Persons Living with a Mental Disability Act, to the extent of the substitute decision maker's powers under the appointment.*

Infection Prevention & Control

Implementation of comprehensive IP&C strategies will help prevent the transmission of pandemic and other infectious diseases with or without the availability of vaccines and antivirals. IP&C measures are fundamental in every aspect of pandemic planning.

Increased volumes and prevalence of symptomatic individuals will require diligent attention to routine practices and additional precautions, health care workers exposure prevention, and facility cleaning and disinfecting standards.

The SDO will refer to existing outbreak policies and protocols for management of respiratory and GI outbreaks as may occur with seasonal flu.

Contact tracing

During a pandemic outbreak, contact tracing of outbreaks can be a very intensive process. Each facility will outline the people responsible to complete this task. Although contact tracing is primarily the role of IP&C during an outbreak other support persons may be identified and trained to assist with this work. Additional information can be found at the following website: https://sharedhealthmb.ca/covid19/providers/

The facility ICP and/or delegate has responsibility to complete contract tracing for residents in the PCH. Occupational Employment Safety Health (OESH), PH and facility leads will determine need to complete contract tracing for staff and visitors depending on exposure location.

Identification and Management of Ill Residents

Early detection and timely response to illness is critical in mitigating transmission. Regular monitoring of PCH residents' health status will identify early changes and will allow for early detection and quick implementation of preventative measures.

Health providers are encouraged to act with an abundance of caution as a proactive measure with any suspect cases.

Confirmation of a positive case in outbreak and pandemic requires immediate action both within the PCH and in the SDO. Prompt informing of a case to site and SDO leadership is required to ensure implementation of a response plan.

A process must be in place to monitor each residents' health status during each shift and staff must be made aware of the importance of reporting any changes in health status inclusive of atypical changes.

A resident showing any symptoms that could be related to a virus or other unknown organism will be immediately placed on additional precautions as outlined by IP&C and Public Health. The additional precautions required may change once the organism has been confirmed.

Notification of any positive case will require immediate consultation with IP&C and MOH for direction in implementing a case management plan as well as implementation of necessary additional IP&C precautions.

COMMUNICATION PROCESS FOR Positive CASE(s)

Once an outbreak of a pandemic organism has been declared the SDO will notify: Communications and Engagement Division (CED) Manitoba, Shared Health Communications, Incident Commanders, Chief Provincial Public Health Officer, Manitoba Health Seniors Care and Chief Nursing Officer for Shared Health. The SDO will notify Communication Services Manitoba, The PCH or SDO will notify CDC Coordinator, IP&C, site medical leadership and SDO LTC representative, OESH and others per their usual SDO process.

Once the outbreak has been confirmed the PCH will notify residents, families, resident designates, and staff using provincially approved scripts/letters to ensure consistent messaging.

The PCH will remind staff of the site/SDO' policies related to media and social media. Staff should be reminded to direct all media inquiries to the appropriate communications department as per established SDO process.

Admissions & Interfacility transportation

During a pandemic and potential associated outbreak at a PCH site, direction will be provided with regards to process of admissions and interfacility transportation. Admissions will be halted during an outbreak (exceptions may be considered depending on the circumstances) which will impact the health system, families and caregivers.

The province will need to determine what resources need to be put in place to support the health system and the individuals affected.

Communication

Timely and up-to-date communication is an important component of any pandemic and outbreak plan. Each facility regardless of site outbreak status, should have an outlined communication structure that allows for up-to-date information to be shared with management, staff and residents/families of the facility and the SDO has a process in place to contact the appropriate individual at the Provincial level.

The PCH will designate a Communications Lead who will be responsible for communications during an outbreak to ensure information is appropriately and effectively communicated to OESH, SDO leadership, IP&C, PH, staff, residents, families and the public and there is a process is in place to handle media inquiries. Facilities will follow the direction provided by SDO senior leaders. The process of communication will be detailed within the site-specific plan. The facility plan will identify contact information for OESH, SDO leadership, IP&C, and Public Health, families, staff and the communication team.

Preparation for an outbreak:

Communication Lead:

The site's Communication Lead will be responsible for communication with relevant SDO leadership, public health officials, residents, families, staff and the public in the

event of an outbreak. The Lead will ensure a communication team is established to support communication responsibilities. It is important to establish alternative and a back up to the communication lead. It will also be critical to have a clinical staff person to support communication especially if the lead does not have a clinical background.

The site-specific plan will establish communication team member(s) and their responsibilities for types of communication.

Contact Lists: In preparation, the facility will need to obtain updated contacts for SDO senior leaders, IP&C, local public health officials, staff, residents and their families and maintain/update these contact lists regularly.

Families

While updating the contact list of family members, staff will need to clarify with residents and families who is the first contact **(i.e. family designate, next of kin, emergency contact)** for health care updates as well as their preferred method of communication (telephone, virtual, email). It is not a requirement for a resident to have a health care directive and proxy in place; however, it is important to have these important conversations with families/residents prior to an outbreak.

During a pandemic associated outbreak, the **first contact/family designate** will receive updates on the resident's health condition, status, and changes. If the resident has a legal representative (proxy/substitute decision maker/committee), and is unable to make their own decision, the proxy/substitute decision maker/committee would be consulted for making health care decisions.

In addition, staff will need to update contact information for the Designated Family Caregiver (DFC). It is essential to establish an understanding with families and residents the role of the DFC, the first contact/family designate and legal representative (proxy/substitute decision maker/committee). During a pandemic associated outbreak, the **first contact/family designate** will be relied on to communicate health status changes or other essential information with the larger family network. It may be necessary to have more than one family contact to receive updates.

During a Pandemic Associated Outbreak:

Communication with families/residents and staff should be daily during an outbreak.

Communication with Families

- Ensure scheduled check-ins with the **first contact/family designate.**

- Ensure regular updates on staffing, visitor protocols, outbreak information and the public health situation at the site are provided often.

- Facilitate virtual options/window options for visiting with families and friends during an outbreak. There are many benefits to arranging visits prior to care conferences/rounds to allow families to "see" residents and be able to ask questions of care providers.

- Consider inviting families and residents virtually to staff huddles/team meets as appropriate.
- For residents who are isolated as suspect and or infected, families should receive a daily call from the clinical team; or, more frequently if their health status has changed.

Communication with Staff

As staff may be redeployed, it is important to provide regular updates. Consider a regularly scheduled call for staff to receive updates. Plan for multiple enquiries from staff when there is an outbreak. Consider a touch point with staff on each shift (call, team meet) to ensure staff can ask questions, and staff understand the contact tracing process, protocols, visitation restrictions and the importance of confidentiality.

Communication with the Public

There will be a process in place for media enquiries within the SDO for devolved personal care homes. Please connect with them if you receive media queries. For non-devolved sites, please follow your organization's media relations policies/processes. However, it is recommended that proactive messaging is provided to the wider community (families, residents, resident/family council and staff) to ensure they receive information on transmission, outbreaks and/or infections/deaths as appropriate. Information should be provided before government news broadcasts/releases so families are not caught off guard and or resort to using social media. Proactive communication will reduce misinformation and build trust.

Types of Communication

General Updates

General updates refer to communication for the larger community (staff, residents and families) and include information on visitor protocols, outbreak information, measures being taken by the facility, and activities. This information is subject to media interest so it is important to be prepared. To ensure accuracy and consistency, scripts and public messaging will need to be reviewed by site lead or designate. Sites may choose to provide general updates through mass email, newsletters, dedicated website with consideration for families who do not have access to technology (recorded message, phone tree, mail out). It is important to refer to original sources of information (i.e. Shared Health, Manitoba government) to ensure up to date information and to prevent misinformation from circulating.

Should the facility decide to host an information session with all families/residents such as a town hall, prepare to follow up with individuals after the session for resident-specific concerns. It is also important to contact families to understand whether their communications needs are being met.

Health Status Updates

The most important concern for families is to have health updates on their family member living in the personal care home. During a pandemic or outbreak, prepare for multiple enquiries from families. As this type of communication is resource intensive, facilities may wish to establish and communicate expectations for communication with the family designate(s), and provide scheduled updates, as well as family-initiated updates.

Communication with family **must** occur when there is a change to the resident's health (fluid intake, eating, behaviour), whether they have been identified as a close contact to the infection, are showing symptoms, have been tested, waiting for testing, contracted the infection or have been cohorted. Facilities should consider virtual options for providing updates involving the resident to provide opportunity for families to have a visual check-in of residents.

It is ideal if clinical staff directly involved with caring for the resident provide the health status updates to family. As this is resource intensive, and depending on the number of staff impacted by the outbreak, staff who have not been working with the resident, may be called upon to assist. The person providing updates will need to have access to clinical staff/resident record to provide updates such as resident's fluid intake, eating, behaviour, and mood. If possible, use virtual options/window visits so that family can "see" the resident. Families will appreciate personalized updates and being able to see their family when in-person visiting is not possible.

Family-Initiated Communications

When a clinical team member cannot respond immediately to family-initiated communication, it is imperative to enlist the assistance of other staff who can provide a call back with a status update (at minimum), and estimated call back time from the clinical team.

Please refer to Section II for further detail regarding communication.

Cohorting

The priority of preventing or limiting the spread of an organism within the PCH will be supported by cohorting strategies. The intent is to keep positive suspect and negative individuals apart to minimize further transmission. Cohorting plans need to be reviewed with regional IP&C regularly. Cohorting recommendations may change depending on current state of outbreak.

Cohort areas should be separate, well ventilated, ideally with a separate entrance and located away from high traffic areas. Consideration should be given to functionality, physical distancing, dining area capacity, cleaning, storage etc. Special consideration is needed for residents with cognitive impairment who are ambulatory.

Staff members should ideally work only with one cohort of residents. If staff are required to work with multiple cohorts, they should move from lowest risk to highest risk of cohorts to minimize risk of transmission. (i.e., from negative to positive cases).

The facility specific plan will contain details for cohorting options within the facility in consultation with management and IP&C. The PCH floor plan will be reviewed during the planning to identify appropriate cohorting locations within the site and will form part of the plan. The current status of the pandemic and residents' status within the site (related to the pandemic organism), also guide cohorting plans. Cohorting recommendations may change through the course of the pandemic depending on these factors.

During the COVID-19 outbreak, Shared Health provided LTC/TC cohorting guidelines to the SDO's. The SDO and facility may develop cohort plans based on these guidelines understanding that this may change depending on organism type.

Roles and Responsibilities

Key leaders within the SDO have responsibility to ensure that all facilities within the organization are supported before, during and post outbreak. Leaders are responsible to ensure that there is regular site communication and are responsive to specific resource requests (e.g., education, staffing, supplies).

Effective outbreak management requires a multidisciplinary approach and involves individuals with different responsibilities. All staff and leadership have a role to play in outbreak prevention and management and a coordinated team approach is essential when managing outbreaks.

In the event of an outbreak, guidelines are required to ensure an appropriate level of care is being provided to all residents as well as process' on how to manage bed capacity and surge capacity expectations.

The facility plan will include task sheets for all clinical and non clinical departments to guide the day-to-day workflow during an outbreak. Role clarity is key to ensure that tasks are not duplicated and all staff clearly understand their responsibilities in managing during an outbreak as well as post outbreak.

A more detailed outline of specific roles and responsibilities within an Incident Management structure is presented in Section II.

Human Resource Planning

Human Resource Planning is a critical component of pandemic planning and outbreak management. Planning should consider a variety of factors including Union contracts, staff availability, and system demands. During an outbreak it is necessary to have sufficient staffing to meet resident care needs safely, adhere to Manitoba PCH Standards, and provide a safe and supportive environment for residents, family, volunteers and staff.

Care in place strategies will likely increase the acuity and complexity of a residents' care and a reduction of staff due to staff illness or isolation requirements should be anticipated.

The facility outbreak plan will address staffing requirements and SDOs, in consultation with Provincial Unified Incident Command, must identify triggers and strategies to secure additional staffing in the event of an outbreak in the PCH.

Identification of critical and nonessential services based on residents' health and functional status and essential facility operations will inform staffing needs. In the event of the site's inability to secure additional staffing in a timely manner, critical resident care needs should be prioritized. One such example is to cross train all available staff/volunteers in feeding and swallowing to ensure nutrition and hydration needs of the residents are met.

Consideration must be given to providing staff with applicable resources and supports during outbreak preparation, planning and response. An increase in acuity and/or number of positive residents will require adjustment to the staffing model/ratio as well as increase in human resources. Monitoring the wellbeing of staff is a key component of outbreak management.

Human resource contingency planning should consider the following:

- Compliance with Public Health Orders, single site staffing orders and other legislation affecting movement of staff.

- Staffing mix and models – it is important to plan staffing mix for various scenarios keeping resident care needs in mind. For example, during the COVID-19 outbreak, there was a greater need for nurses to manage residents in place who were sick and required frequent nursing assessments and interventions such as medication administration. Daily care physician and or NP presence would also require higher nursing utilization.

- Considerations to adjust baseline staffing.

- Consideration to adjust staffing ratios include:
    - Size of the facility
    - Number of ill residents
    - Acuity of ill residents
    - Extent of the outbreak
    - Geographical location of the facility

- Identify when to seek assistance from external staffing support including Redeployment Teams and other expedited hiring sources.

- Plan for implementing orientation, education and training for re-assigned or redeployed staff, volunteers and family caregivers.

- Cross training of staff

- Optimization of staffing rotations.

- Contingency planning should take into consideration option for delegates for all positions including leadership roles, clinical care roles and facility support roles.

- Consideration will be given to adjusting baseline staffing compliments to meet increased staffing workload and increased resident service/ care needs. Examples include but not limited to:
    - residents were isolated in their rooms,
    - increased donning and doffing to enter rooms,
    - delivery of meal trays,
    - bed bathing versus tub baths,
    - increase in resident falls
    - increase in need for resident supervision

Monitoring the wellbeing of staff is a key component of outbreak management and key responsibility of Human Resources.

Please refer to Section IV: Pandemic Staff Plan for further direction.

Orientation and Training

Should the need arise for external staff to support the PCH with care provisions, applicable training and orientation will be required based on the health care providers experience and individual competencies. The SDO will develop orientation resources to ensure safe quality care continues to be provided to all residents during an outbreak.

The orientation and training plan will contain at a minimum:

- Health care providers practicing within usual scope of practice will require brief orientation.
- Health care providers adding additional skills to their practice will require additional training.
- Balanced approach for timing of training, particularly for those new to the environment is key. A refresher may be required when a gap in time exists between training and ability to apply learning.

Physician/Nurse Practitioner services

Daily on-site physician and/or Nurse Practitioner (NP) rounds will need to immediately be put in place once a pandemic associated outbreak has been declared. Long Term Care Medical leads in consultation with Public Health and SDO/site incident command, will provide direction to Physicians/Nurse Practitioners with regards to the most appropriate approach to management of suspect and positive cases.

All staff are required to work to their full scope of practice to support PCH residents.

Please refer to Section V: Roles & Responsibilities of Medical Leadership & Medical Staff during a Pandemic/Serious Outbreak for further direction.

Designated Family Caregivers and Visitor

Each PCH resident, in collaboration with PCH staff, will identify designated family caregivers as permitted in provincial guidance who will be supported to continue their involvement in providing active care and support to the resident's emotional wellbeing, health, and quality of life. The designated family caregivers will be documented in the resident' health record.

It is important to distinguish between designated family caregivers and visitors. Family caregivers are active and essential partners in care for their family member residing in a PCH. They are a key support and are the voice of the vulnerable resident who cannot always speak for themselves. They may help with physical tasks like eating, social and emotional support, as well as connection to the larger family.

Evidence suggests that a resident's health and wellbeing is at higher risk without the presence of family caregivers.

Sites will support regular communication and visitation from visitors and designated family caregivers dependent upon the type of outbreak organism. Visitation principles may change during an outbreak depending on severity and transmission concerns. PCH site operators will actively support the ability of residents to remain connected to their loved ones through virtual visits, indoor/outdoor visits in alignment with PH orders and provincial guidelines.

Visitation principles will be communicated to the SDO by the organization responsible for pandemic and subsequent outbreak response. Visitation principles may change during a pandemic depending on severity and transmission concerns.

Visitor Restrictions: the need to maintain connections

Should visitations be restricted, visiting supports will be essential to assist families and residents with maintaining these essential connections? Virtual options are especially important for families who are not the first contact or DFC who just need to see or hear the resident. The facility may consider designating staff/volunteer to help with virtual visiting options and to help address technology questions to enhance virtual visitation for family members. It is essential that virtual visitation be supported during a complete shut down.

Sites will provide designated family care givers and visitors with instruction regarding routine practices, any necessary PPE requirements, and/or required additional precautions with each visit.

A process will be developed to allow for rapid problem solving related to concerns brought forward from residents/family. This will allow issues to be addressed in a timely manner.

A tracking system is in place for all visitors to the PCH to facilitate contact tracing if needed.

Mental Health and Wellness

Mental health and wellness are an important part of overall health and wellbeing. It affects how we think, feel, and act. It also affects how we handle stress, relate to others and make choices during an emergency. It is imperative that the SDO have a resource package for staff, residents and families during an outbreak.

Supply Chain Management

Supply use during an outbreak will increase and there will be a continued need to closely monitor supply levels and project demand across various departments to ensure timely response in procurement. A facility level contact(s) should be identified that will monitor stock levels and usage regularly across all departments (with support of department leads) in a non-outbreak status as well as monitor stock levels at least daily during an outbreak.

Minimally, the following must be monitored:

- Appropriate inventory of PPE
- Isolation Carts
- Storage containers
- Alcohol-based hand Rub (ABHR) for hand hygiene
- Soap and paper towels for hand washing
- Appropriate inventory of approved cleaning and disinfectant supplies
- Appropriate numbers of waste receptacles
- Appropriate inventory of testing supplies
- Outbreak signs and additional precautions signs

Staff should be aware of where all supplies are stored, how to access, and who to notify if stock levels are reaching a minimum quantity.

Post-Outbreak

Ongoing monitoring for a re-emergence of symptoms or complications is necessary during the outbreak and once outbreak has been declared over.

Following the termination of the active outbreak phase, the facility will have a plan in place for the restoration of infrastructure, services and programs. Scaling down of monitoring to normal operations to be planned in advance to ensure the facility is able to remain current with staffing supports

Security

The facility in consultation with SDO leaders will determine the need to implement security personnel. Security services may be required to ensure safe storage of high demand supplies to prevent loss due to theft. Security resources may also be required

if outbreak intensifies to facilitate a calming presence, and manage restricted entry into the building should additional visitor restrictions be implemented.

Facilities that do not have security staff on site may consider strategies included but not limited to the use of minimal entry/exits/ lock down or hiring outside agencies.

This document has been produced with the input of representatives of Manitoba's Health System Service Delivery Organizations (Shared Health, Northern Health Region, Prairie Mountain Health, Interlake-Eastern Regional Health Authority, Southern Health-Santé Sud, and Winnipeg Regional Health Authority), the Department of Health and Seniors Care, and Revera. Technical expertise and professional advice have also been incorporated from provincial Infection Prevention and Control, the Provincial Redeployment and Recruitment Team and Shared Health's Emergency and Continuity Management Service.

Resource Documents

Long Term Care/Transitional Care Cohorting Guidelines (Nov 30, 2020)
Personal Care Home resident visitation principles (April 16, 2021)

References:

Centres for Disease Control and Prevention
https://www.cdc.gov/csels/dsepd/ss1978/section11.html

Alberta Health Services (2020); Continuing Care Pandemic Operational Guide (COVID-19).

Canadian Pandemic Influenza Plan https://www.canada.ca/en/public-health/services/flu-influenza/canadian-pandemic-influenza-preparedness-planning-guidance-health-sector.html

Section II

Emergency Continuity Management for A Pandemic in Manitoba Personal Care Homes

Pandemic Plan Objectives

A number of goals and objectives have been established to ensure that the Personal Care Home(s) (PCH) continue to maintain the ongoing operations of the organization through a coordinated response for a Pandemic. The goals and objectives are as follows:

- To develop a plan that ensures the PCH facilities of Manitoba readiness to respond appropriately to a pandemic.

- To achieve the confidence of the public in the PCH facilities readiness to respond to a pandemic.

- To ensure optimal coordination between the PCH facilities, Shared Health and Manitoba Health and Seniors Care.

- To ensure health care providers have access to the appropriate training, education, infection prevention and control practices and equipment and other supports to protect themselves and patients/clients from exposure to a novel virus.

- To ensure the continuity of services with minimal disruption.

- To ensure minimal disruption and impact on our staff and the population we serve.

- To ensure that we work collaboratively with all external partners through established communications processes.

- Consider the wide range in organizational culture, historical, cultural and geographical needs, including those of First Nations communities.

- Examine this work through the lens of residents, their families and site staff, and include their perspective

- Ensure a staffing complement that can be deployed and accessed quickly during an emergency.

- To ensure that the plan is reviewed at a minimum of every three (3) years or when major changes to protocols, process, or procedures occur.

- To decrease the number of individuals exposed to the novel virus.

- To reduce morbidity and mortality associated with pandemics.

- To ensure the ability for nimble execution implementation and utilization of an Incident Management System in managing a pandemic.

- To return PCH's to a state of normalcy post pandemic.

This plan was developed using risk management principles. The threat of a new virus is considered an 'inevitable event'. The impact on the health system as well as societal disruption is considered high. For PCH the impact will occur in the area of resource requirements, both human and material. As well, lessons learned from any pandemic experiences will be incorporated.

From a planning perspective we wanted to mitigate the threat by having a plan that speaks to reducing the burden on high impact areas. This meant keeping the plan functional with minimal changes to the organization. Pandemic assumptions were based on Public Health Agency of Canada – Canadian Pandemic Influenza Plan for the Health Sector:

a. Initiate an Incident Management Structure.

b. Program and Service processes would be maintained with as little disruption as possible.

c. Programs would prioritize service delivery, based on resource availability.

d. Due to the lengthy duration of the pandemic, the organization will use a modified Incident Management System (IMS) model for the interval of the pandemic.

Pandemic Planning Principles and Assumptions

A pandemic is an inevitable event; however, the timing and epidemiology of the next pandemic is unpredictable. Planning is based on the following assumptions:

Absenteeism

The magnitude of a pandemic will create concerns related to total work absenteeism. As a healthcare industry, PCH's will plan for a total workplace absenteeism rate of between 20% and 25% during the peak at a minimum two- week period with lower rates in the preceding and subsequent weeks.

The prudent planning assumptions are based on modeling conducted by the Provincial Pandemic Recruitment and Redeployment team (PRRT). They reflect normal absenteeism, peak illness and care giving absenteeism and a prudent planning buffer to account for heterogeneous effects across work units, possible workplace-avoidance absenteeism and possible absenteeism stemming from public health measures such as school and daycare closures.

Response

It is unlikely that an effective vaccine will be available at the start of pandemic activity in Canada but it may be available for a second wave.

Mass immunization campaigns will occur when sufficient quantities of the new vaccine are available; this will increase the demand for public health human resources.

The use of antivirals to decrease the risk of transmission from the first cases infected with a novel virus and their contacts will be considered as a strategy to contain or slow

the spread of novel viruses that have pandemic potential and that are identified in Canada. The use of this strategy will be limited to cases identified early in the Pandemic Alert Period in Canada. During the Pandemic Period, this strategy will change to the nationally agreed upon strategy for the pandemic period.

Manitoba Health and Seniors Care (MHSC) in collaboration with Shared Health (SH) will manage pandemic vaccine supply when a pandemic vaccine is available, as well as the supply and distribution of antiviral drugs which are contained within the National Antiviral Stockpile.

Manitoba Health and Seniors Care will provide technical expertise during the pandemic period in order to inform the national response and facilitate consistency in response activities across Canada.

Legal Considerations

The legal considerations that arise in the context of pandemic preparedness and response are varied and complex. Given that a pandemic is a global concern, planning and preparation requires the coordinated efforts of all levels of government within Canada in addition to international cooperation.

PCH's in collaboration with MHSC will work within a legal framework that attempts to balance the rights of individuals (privacy, equity) with the response to protect the public from harm and the right to the worker to work in a safe environment.

Legislation already in existence includes The Emergency Measures Act, The Public Health Act, The Regional Health Authority Act and The Freedom of Information and Protection of Privacy Act. This legislation will help guide PCH's response to a pandemic.

Manitoba Health and Seniors Care will ensure that an effective and transparent process is followed when responding to a pandemic.

Ethical Considerations

The goal of our pandemic plan is to minimize the morbidity and mortality as well as to minimize society disruption if a pandemic should occur. To achieve this goal, it brings forth a number of ethical principles. Ethical analysis helps to identify in a logical and transparent way of how to "do the right thing". This is not always easy as there may be conflicting ethical principles as well as other factors, such as regulation, scientific evidence and comparable policies in other provinces, which must be taken into account. PCH's will adopt a process that is transparent, inclusive and reflects the values of our stakeholders and staff.

Manitoba Health and Seniors Care has an Ethics Framework to assist staff in ethical decision making.

The following are substantive ethical principles identified in the development of a Pandemic Plan:

Freedom of Liberty - During a pandemic there will be cause to limit movement of individuals in order to protect the health of our stakeholders and staff. The PCH will

ensure that the restriction will be proportional to the level of risk to the population and will ensure the least restrictive means is utilized.

Privacy - Residents of PCH's are entitled to their privacy including their health information. Release of health information needs to be balanced against the need to protect the public. The PCH will ensure that health information is only released to the extent that it is needed to protect the health of the public. The PCH will follow the guidelines as stated in the Freedom of Information and Protection of Privacy Act.

Equity - All Manitoba residents are entitled to receive health care services when they want. MHSC will ensure these services are available. During a pandemic, restrictions will be applied to some services as decisions will have to be made around which services will need to be interrupted, who should receive antivirals and vaccine allocation in a period of short supply as vaccine production will be limited initially. MHSC will ensure services are equitably distributed with no discrimination. Individuals who are not in the priority groups will be informed accordingly and treated with respect and dignity.

Duty of Care - This principle balances the risk to the health care worker, friends and family with the benefit of providing care. PCH's will ensure there is adequate protection given to health care workers through education, information and the development of practice guidelines.

Trust - This is essential in the relationship with PCH's and its employees as well as between health care workers and the general public. PCH's will utilize a decision making process that is accountable, ethical and transparent.

Abbreviations:

BCP   Business Continuity Plan
IAP   Incident Action Plan
ICP   Infection Control Professional
IMS   Incident Management Structure
IP&C   Infection Prevention & Control
MHSC Manitoba Health and Seniors Care
MOH   Medical Officer of Health
NP   Nurse Practitioner
OESH   Occupational and Environmental Safety and Health
PCH   Personal Care Home
PH   Public Health
PPE   Personal Protective Equipment
POA   Power of Attorney - *is the legal authority contained in a written document that allows someone else to manage a person's legal and financial affairs.*
PRRT Pandemic Recruitment and Redeployment Team
RHA   Regional Health Authority
SDM   Substitute Decision Maker*
SDO   Service Delivery Organization
TCC   Transitional Care Centre

*Substitute decision maker has been used throughout this document to refer to the following legal representatives (a) **a proxy** appointed by a resident under The Health Care Directives Act, to the extent of the proxy's powers under the health care directive; (b) **a committee** appointed for a resident under The Mental Health Act, to the extent of the committee's powers under the appointment; (c) a **substitute decision maker** for personal care appointed for a resident under The Vulnerable Persons Living with a Mental Disability Act, to the extent of the substitute decision maker's powers under the appointment.*

Business Continuity

Business Continuity is an integrated process involving the development and implementation of activities that provides for the continuation and/or recovery of critical service delivery and business operations in the event of a disruption such as a Pandemic.

A Business Continuity plan is documented collection of procedures and information that is developed, compiled, and maintained in readiness for use in an incident to enable an organization to continue to deliver its critical activities at an acceptable pre-defined level.

Overview

In the event of a Pandemic, it is important that core people, skills and supplies are available to keep essential health care services and business operations functioning. The PCH Pandemic Plan will focus on measures and arrangements to ensure the continuous delivery of critical services.

In the same way that the generally-accepted best practices for emergency planning call for a flexible, adaptable 'all-hazard' approach to dealing with disruptions, BCP is designed to help an organization continue providing its basic and most critical functions during a disruption, the obligations to those who depend on our services, the exposure to risk our organization is willing to tolerate, and the requirements (such as equipment, data, personnel and facilities) required to deliver the required services. From this, a plan is prepared to identify the tasks, procedures and organization required to work through a disruption. A thorough BCP also includes provisions for returning to a normal state-of-operations after a disruption has occurred.

Objectives

- Guide PCH's management of human and other resources in responding to a Pandemic
- Ensure that resources are available to all patients/clients who access the system.
- Store, distribute, and maintain an eight-week stockpile of equipment and supplies at designated sites.
- Revise the equipment and supply listing as necessary.

- Establish and maintain a list of local and alternative suppliers/services.

Human Resources

A Provincial Pandemic Recruitment and Redeployment Team has been developed that will guide the organization with variety of labor/human resource issues that will need to be addressed during a pandemic.

Such issues include but are not limited to:

- Declaration of Emergency
- Principles of Redeploying Staff
- Workplace Safety & Health – Right to Refuse
- Immunizations
- Training for Alternate Functions
- Resiliency in the Workforce
- Volunteers

Materials Management

Equipment and Supplies

Materials Management is responsible for central purchasing, storing, distributing, securing, and transporting supplies. Supplies may be any product, including but not limited to paper products, incontinence supplies, correspondence, gloves, gowns, etc.

Incident Management

An Incident Management System is an internationally accepted best practices and the principles are based on and agreed to by the Federal/Provincial/Territorial Network on Emergency Preparedness and Response. An IMS is an organizational and planning system that defines the roles and responsibilities to be assumed by personnel and the operating procedures to be used in the management and direction of emergency incidents.

The purpose of an Incident Management Structure (IMS) is to ensure the rapid decision-making and action necessary in an emergency is properly informed, resourced, implemented, communicated and documented.

Specifically this will include:

- Overall management and coordination of emergency operations at a Site/Service level,
- And/or Corporate/Provincial level.
- Coordinating and maintaining liaison with appropriate Federal, Provincial, and Municipal

- government departments, with partners, key stakeholder agencies and appropriate

- Private sector organizations.

- Managing the acquisition and allocation of resources, supplies and other related support.

- Establishing priorities and adjudicating conflicting demands for resources and/or support.

- Coordinating inter-jurisdictional mutual aid.

- Activating and using communication systems.

- Preparing and disseminating emergency public information; disseminating community

- Warnings.

- Collecting, evaluating and disseminating information and essential data.

- Responding to requests for human resources and other support.

- Restoring essential health services.

- Recovering from the incident as an organization.

Each PCH site is encouraged to have a pandemic response governance structure that supports an overall Incident Management System approach to ensure pandemic information is effectively communicated with staff, clients and the public.

The IMS may be activated in full whereby resources including human resources are activated in full or in part. The IMS may also be activated in a "virtual" format, at least initially, whereby the coordination of the pandemic event is conducted in a virtual environment.

INCIDENT MANAGEMENT SYSTEM POSITION TASK SHEETS

Incident Management System task sheets are used by each specific section that make up the overall response.

KEY FUNCTIONS OF THE INCIDENT MANAGEMENT SYSTEM

The Incident Management System (IMS), when activated, has a number of key functions that works toward sound management of a pandemic event which impacts PCH's both directly and indirectly. Key functions of the PCH's Incident Management System include:

Chain of Command is implemented specific to the management of a disaster/emergency event and falls outside of the normal chain of command for normal operations.

Common terminology permits diverse incident management internally and with external organizations utilizing common terminology or "one language".

Incident Action Plans (IAPs) are developed by the planning section based on the objectives identified by the Incident Commander and are an organized course of events that addresses all phases of incident control within a specified period of time. The IAP identifies objectives, strategies and tactics to manage a disaster/emergency incident. IAP's are approved by the Incident Commander before operations are initiated.
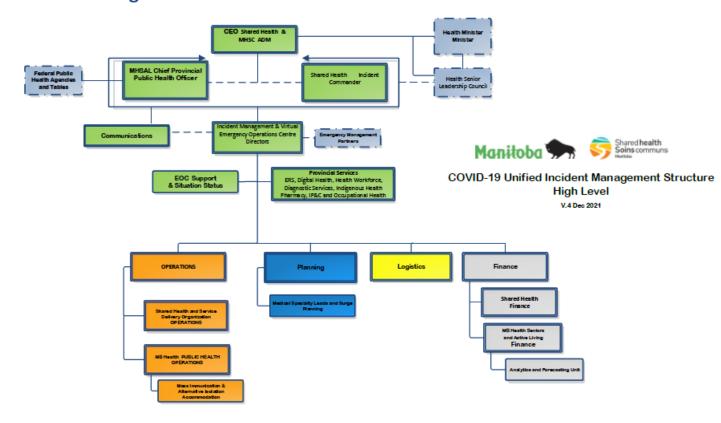
Applicability to varying types and magnitudes of disaster/emergency events whereby the IMS can be scaled up or scaled down to meet the particular needs of a specific incident.

Documentation of the incident for the purpose of determining what went well and what areas require improvement. The documentation forms the permanent record of the incident.

Incident Management Structure

COVID-19 Unified Incident Management Structure
High Level
V.4 Dec 2021
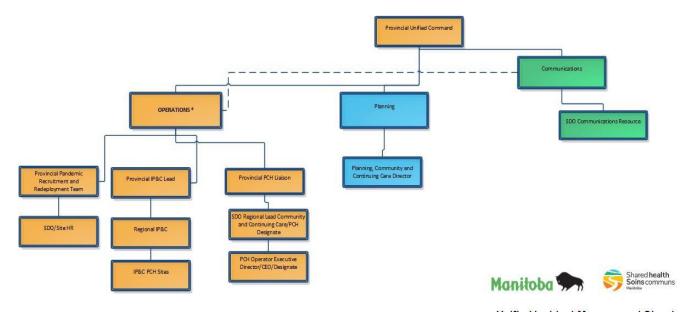
The future Health Structure within Manitoba requires that MHSC and Shared Health should jointly manage a Pandemic, using the underlying principles of Incident Management, with each SDO having capacity to institute an Incident Management structure reporting to a provincial operations section. The provincial structure will be referred to in this document as "Unified Incident Management". This would allow for greater management and communications for the PCH's in Manitoba. Personal Care Homes would be aligned within the Operations Section of the IMS structure.

Unified Incident Management Structure
Operations - Personal Care Home
V. 4 November 3, 2021

*There are more functions within Operations during a Pandemic, above is an illustration for PCH operations specifically

Manitoba Personal Care Home Pandemic Response Plan

Roles & Responsibilities

Group	Responsibility
Operations Chief, Pandemic Unified Incident Management	• Organize and direct aspects relating to the Operations Section. • Carry out directives of the Provincial Incident Commander, including the Incident Action Plan. Facilitate the passage of information to and from Acute Care, Community Care, and Personal Care Home Operations. • Coordinate with the Planning, Logistics, and Finance Section Chiefs of Pandemic Unified Incident Management as necessary
Provincial Personal Care Home Liaison (NEW)	• As a member of the Provincial Operations section, the Provincial Personal Care Home Care Liaison is

	responsible connecting with all Personal Care Homes for monitoring the PCH services component of the Incident Action Plan during the incident.
	• Assists in organizing and coordinating the relevant PCH response.
	• Facilitates the passage of information to and from the Provincial Operations Section to Service Delivery Organization PCH operators.
	• Provide advice to the Provincial Operations Section Chief regarding plan development involving PCH Operations. With approval of the Provincial Operations Section Chief, liaise with the relevant members of the PCH Operation (s) involved.
	• Understand the operations, capabilities, and resources involved with PCH facilities, including resident capacity.
	• Coordinate with the Provincial Incident Commander(s) as necessary to understand external agency involvement with PCH Operations Teams.
Planning, Community and Continuing Care Director, Pandemic Unified Incident Management	• Lead and coordinate development of Provincial guidelines and directives for the PCH sector
	• Support a collective and integrated Provincial Pandemic response in consideration of the available community and continuing care resources within the Province
	• Contributes to the review and revision of the SDO PCH pandemic planning including Regional response plans based on evolving pandemic situation and Provincial pandemic planning and response needs

	• Collecting, evaluating, and disseminating information and essential data and information for Provincial planning and reporting purposes
SDO Regional Lead Community and Continuing Care/ PCH Designate	• Creation of a regional level pandemic response structure that includes PCH operators. • Ensure that the SDO and each PCH has Pandemic response plan including regular information sharing and escalation processes between SDO and operators • Coordinates the pandemic response of all SDO owned, operated, and its service partners (licensed affiliated and private PCH Operators) • Identifies pandemic response implementation and communication strategy • Monitors risks associated with Pandemic planning within the SDO and PCH sites • Establishes SDO staffing contingency plans with triggers and processes for PCHs, including redeployment plans of clinical, support, and IP&C resources from other areas including IP&C supports in an event of potential crisis at a site • Responding promptly to requests for staffing and other supports including equipment and supplies from the PCH sites that may be having difficulty • Establishes physician coverage in PCHs in collaboration with SDO and PCH Medical Directors • Assigns responsibilities within the SDO and PCH sites in partnership

	- with the PCH site leadership in the event of a pandemic response - Escalate/ Notify Operations Chief, Pandemic Unified Incident Management of any outbreaks, staffing, and other emerging risks
PCH Site Leadership (May be Site Manager, Operator, Executive Director, CEO or Designate)	- Ensure that site has completed pandemic response plan based on SDO guidelines - Provide pandemic response training to all staff and volunteers as appropriate for their role - Support SDO Regional lead/ designate in implementation of a Regional and Provincial pandemic response including Pandemic Unified Incident Management guidelines and initiatives - Proactively identify and address resource needs within the respective site - Ensure and implement plans to meet client care needs during outbreak - Identify risk(s) associated with pandemic response to SDO Regional Lead/Designate promptly - Identify a communication strategy in collaboration with SDO communications in relation to a pandemic response to inform staff, clients, family and public. - Identify program and site contacts as required by the SDO - Track expenses related to pandemic response (e.g. staffing, overtime, equipment, and supplies, etc.
Shared Health Communications Lead	- Support the development and formatting of both strategic and

	templated operational documents for use across SDOs. • Create templates and posts final versions of materials that have undergone appropriate review and approval cycles. • Seek the input of subject matter experts to inform the development of key messaging, public messaging, FAQs and other materials by segmented audience: staff, residents, families, public, and media. • Liaise and coordinate communication activities across SDOs and with government entities. • Responsible for media response on items related to provincial guidance. • Maintain up to date, information source – the single source of truth. • Escalate and elevate items in need of response.
SDO Communications Resource	• Support the development of operational documents for use across an SDO. • Where resources have been created for provincial distribution, SDOs are responsible for the distribution of the provincial document to appropriate audiences throughout an SDO. • Support the development of additional resources to support localized implementation. • Liaise and coordinate communication activities with operators. • Responsible for media response on items related to local/SDO guidance. • Escalate and elevate items for provincial awareness and/or response.
Provincial Pandemic Recruitment and Redeployment Team	• Receives requests for resources • Utilizes redeployment list to identify available resources to match to resource requests

	- In collaboration with clinical leadership led by IC, identifies where redeployable resources which be redeployed - Coordinates redeployment of those resources to receiving sites requiring those resources - Identifies available resources in the pandemic Casual Pool to meet outstanding resource needs not met through redeployment - In collaboration with clinical leadership, deploys pandemic Casual Pool resources to areas of need - Posts positions and recruits for classifications not currently in the pandemic Casual Pool and/or where there are insufficient resources in the pandemic Casual Pool to meet outstanding resource requests - Deploys new hires from pandemic Casual Pool to meet resource requirements - Contacts pandemic Casual Pool staff resources to determine if any interest in additional deployment opportunity or transfer in additional deployment opportunity to meet changing resource needs - Works with educational institutions to identify/develop micro-credentials and courses required to assist with resource needs, i.e. UHCAs, etc. - Works with educational institutions to inform students of available opportunities - Works with associations/regulatory bodies to inform members of available resources - Tracks resource requests, pandemic Casual Pool hires, redeployments/deployments, etc.
SDO/SITE HR	- Working with provincial and SDO incident command, sites identify

	services or portions of services that can be reduced
	• Identify staff impacted by service reductions including:
	- Classification
	- EFT available for redeployment
	- Skill set
	• Identify staff available for redeployment
	• Assist with coordination of redeployed staff to PCH requiring resources
	• Sending Site discusses redeployment with impacted staff being redeployed as per redeployment process
	• Receiving Site prepares welcome for redeployed staff together with orientation and any required training
	• Receiving Site maintains timesheet for redeployed staff and submits to Sending Site who ensure redeployed staff are appropriately paid
	• Sites regularly provide updated redeployment information spreadsheet as service delivery needs change
Provincial IP&C lead, Pandemic Unified Incident Management	• Informs and endorses pandemic response plan with respect to IP&C, i.e., IP&C 'section' and IP&C implications within other sections
	• Identifies and provides direction to sites to proactively manage risks
	• Establish/recommend appropriate IP&C measures during non-outbreak and outbreak situations to minimize infection transmission risk and ensure appropriate IP&C management of infections

	- Identifies and provides recommendations for IP&C risks associated with pandemic planning and response - Participates in support and redeployment plans as deemed appropriate by IP&C and/or SDO/site lead(s) - Respond to IP&C-related requests - Work/collaborate with site IP&C/designate to review proposed plans (e.g., IP&C case and contact management) and inform appropriate IP&C measures for implementation - Escalate/Notify Operations Chief, Pandemic Unified Incident Management of any outbreaks, and other IP&C-related emerging risks - Identify risk(s) associated with Pandemic response to SDO Regional Lead/Designate - Contribute to proactive and responsive communication strategies in collaboration with SDO communications in relation to IP&C risks and measures to inform staff, clients, family and public - Inform HR strategies from an IP&C perspective - Provide IP&C guidance to inform appropriate role and direction to external supports such as Red Cross, additional leadership supports, etc., so these resources are clear on the scope of IP&C and their responsibilities to engage provincial, regional and/or site IP&C - Advises on PPE products and use, optimizing supply in times of constraint

Regional IP&C	• Reviews and informs IP&C management of contacts, cases, and outbreak measures in accordance with provincial guidance. • Declares outbreaks and makes decision on resolution in consultation with sites. • Advises on IP&C measures and recommended improvements/adjustments to ensure alignment with provincial standards and guidelines. • Provides consultative advice, site visits to review practices. • Attends to sites as required to support and assist with determination of necessary and appropriate IP&C measures.
IP&C PCH Sites	• Manages cases contact and outbreak in collaboration with regional IP&C according to Shared Health guidance. Responds to site-based IP&C-related requests for information. • Establishes a site-based mechanism to review and inform appropriate implementation of IP&C measures and pandemic plan. • Participates in the development of site-based implementation plans to audit IP&C practices. • Escalates IP&C risk issues for awareness and collaborative problem solving. • Consults regional IP&C to inform declaration of outbreaks and resolution

These roles and responsibilities are guidelines based upon current events and are intended for reference only.

Communication

Improved communication involves the establishment of clear channels of communication, both from Incident Command to SDOs and PCH Operators but also up from PCH Operators to SDOs and/or Incident Command.

This requires clear coordination, an understanding of role and responsibility, and clear communication and escalation processes.

Incident Command to SDOs

Incident Command must establish the single source of truth for information related to pandemic response. The single source of truth must be regularly maintained and be kept up to date. Information must be communicated consistently by the single source of truth to SDOs. SDOs are responsible for distribution to operators and must avoid unnecessary redesign or repackaging of established provincial guidelines.

SDOs to Operators and SDOs to Incident Command

SDOs must establish regular frequent meetings with PCH operators to ensure pandemic information and guidelines are effectively communicated. SDOs are the intermediary between Incident Command and the PCH Operators, responsible for flowing guidance and decision-making information to Operators as well as flowing risk assessment from Operators up to Incident Command.

Operators to SDOs

In turn, PCH Operators must follow guidance developed provincially and approved by Incident Command. Operators are expected to keep SDOs informed of any emerging issues or risk and should ask for assistance as required through their SDO Regional Lead for Community or Continuing Care or designate.

Formal Escalation Structure and Process

SDOs must establish a written escalation structure and processes. This must be shared with PCH operators to support rapid decision-making and to ensure appropriate support for PCHs in need.

PCH in need could include those struggling to:

- control outbreaks,
- complete infection prevention and control assessments,
- ensure appropriate staffing levels,
- access personal protective equipment (PPE),
- meet basic resident needs, etc.

Triggers

Operators must keep SDOs informed of any emerging issues and are expected to request assistance as required. As outlined in further detail in the Pandemic Staffing Plan, **key triggers** requiring escalation to SDOs include:
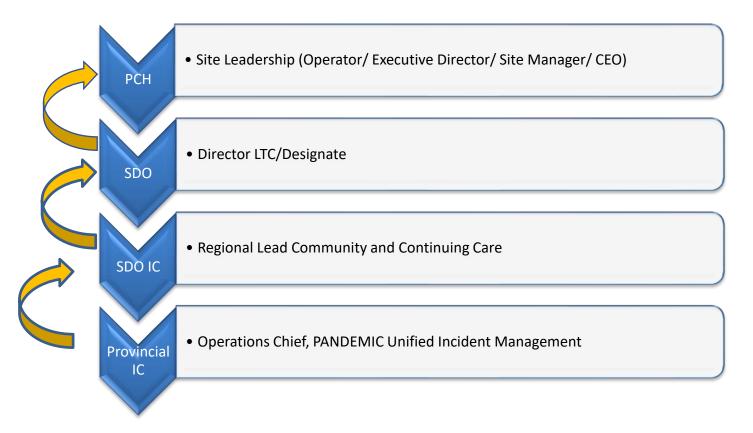
- Any reduction in staffing levels by 5-10% -- As outlined in the Pandemic Staffing Plan, PCH operators, in consultation with SDO PCH leadership will assess the priority areas of service and engage in planning and responding with appropriate support.

- Any spike in resident illness where more than 10 per cent of residents are ill at the same time, related to pandemic, outbreak or other any other identified situation where the potential for management at the site level is a concern. Additional factors for consideration are outlined in the Pandemic Staffing Plan.

Communication Escalation Structure:

Two-way flow of communication in the Incident Management System is imperative to ensure rapid decision-making and action necessary.

PCH
- Site Leadership (Operator/ Executive Director/ Site Manager/ CEO)

SDO
- Director LTC/Designate

SDO IC
- Regional Lead Community and Continuing Care

Provincial IC
- Operations Chief, PANDEMIC Unified Incident Management

Communications Planning

Within any situation requiring provincial escalation or a request for assistance, Operators must work with SDO communications to develop a plan to keep staff, residents, families, and public informed.   Refer to Emergency Communications Framework.

SDO communications will be required to notify the Provincial Lead, Strategic Communications & Stakeholder Relations – Shared Health.

RACI chart—also known as a responsibility assignment **matrix**—is a simple roles and responsibilities **matrix** used in project management. A **RACI** chart defines whether the people involved in a project activity will be Responsible, Accountable, Consulted, or Informed for the corresponding task, milestone, or decision.

See Appendix A for completed RACI Matrix

Annual Review

It is important that this plan be reviewed on an annual basis to ensure that it is a familiar process for the senior leadership of the PCH's to be able to provide direction to all staff in the event of a Pandemic.

Operational Cycle

It is important for the Incident Commanders to establish a cadence of meetings to ensure that information is flowing in a timely manner from the bedside to the Incident Commander, and back again. In the beginning of a response the frequency could be as often as every hour, however as the duration of the event continues the urgency of meeting frequency will decrease to daily, or multiple times a week.

Ensure the day begins with an Incident Commander meeting, followed by the entire Incident Management group meeting where the Incident Action Plan (IAP) is established and every section will know its work for the operational cycle.

Emergency Management Designate

When managing a Pandemic each PCH shall identify an Emergency Management designate and a back up to assist with the event. In addition, each facility should create a contact list, or update the list that is in the facility Emergency Plan.

Training/Exercise

It is strongly encouraged that a training exercise occurs annually with all staff to review, understand, and become comfortable with an incident management system, in addition to the facilities Emergency Plan.

RACI Matrix

R- Responsible (Do the work or assign the work to get the task completed) / A - Accountable (Ultimate answerable for the task being completed) / C - Consulted (Their opinions are sought) / I - Informed (They are kept up to date on the progress)	PCH Site Leadership (Operator / Executive Director/CEO / Site Manager)	SDO CEO/ Regional Lead	Provincial PCH Liaison	Operations Chief, Pandemic Unified Incident Management		Planning, Community and Continuing Care Director		Communications		Infection Prevention & Control	Human Resources
				Shared Health Lead	SDO	Prov.	SDO	Site	PRRT	SDO	Site
Outbreak Preparation - During Pandemic											
During Outbreak											
Implementation of Pandemic Plan											
Sets strategic direction for the province and for PCHs regarding specific actions required relevant to the disease	I	I/C	R/A	C	C	C					
Development of strategic guidelines and directives for the PCH sector	C/I	C/I	C	C	R/A	C		C		I	
Identifies pandemic response implementation and communication strategy for all SDO,owned, operated and	C/I	R/A	C	I				I/C		I	

its service partners (licensed affiliated and private PCH Operators).													
Coordinates the pandemic response implementation strategy for SDO owned, operated and its service partners (licensed affiliate and private PCH Operators).	C/I	R/A	C		I				I/C				
Reviews infection prevention and control direction, disease- specific actions required and strategic guidelines with SDOs		I	I		R			R/A	I				
Reviews direction and disease- specific actions required with PCHs.	I	R/A	I						R/C	I			
Reviews direction and disease- specific actions required with First Nations PCHs.			R/A	I									
Operationalizes and implements the strategic guidelines as identified by Unified Incident Command, including any disease- specific actions required.	R/A	I	I							C			
Development and formatting of strategic	I/C	I/C	C		R/A	R/A		C	I				

and/or templated operational documents for use across SDOs											
Supports the development of operational documents for use across an SDO.	C/I	R/A	C/I				R/C	I/C	I		
Distributes provincial documentation to SDOs.			I/C	R/A	R/A	R					
Distributes provincial documentation to PCHs.		R/A	I/C								
Distributes provincial documentation to First Nations PCHs			R/A	I							
Identifies site individuals responsible for implementing key tasks as outlined in the pandemic plan. Tasks may be specific to key areas, such as contact tracing, communication, human resources, supply management. Establishing priorities and reassigning duties may be required.	R/A	I	I							I	I
Develops a site communication strategy in relation to a pandemic response to inform staff, clients, family and public. This may include identifying and assigning this	R/A	I	I				I				

Task													
task to an individual.													
Communicates and provides information to PCH Staff and Families.	R	A	I										
Communication of provincial Visitation principles for visitors and designated family caregivers.	R	A	I										
Proactively identifies needs/issues and develops provincial level strategies to manage: human resources, resident care, supply/resources, education and training, and infection prevention and control.	I	I	I/C	R/A/C	R/A/C			C			C		
Identify provincial level risks associated with pandemic response.	I	I	I/C	R/A/C	R/A/C			C			C		
Proactively identifies needs/issues and develops regional level strategies to manage: human resources, resident care, supply/resources, education and training, and infection prevention and control.	I/C	R/A	I/C	I	I/C				C		I	C	
Identify regional level risks associated	I	R/A	I/C	I	I/C				C		I	C	

with pandemic response.											
Proactively identifies needs/issues and develops site level strategies to manage: human resources, resident care, supply/resources, education and training, and infection prevention and control.	R/A	I/C	I/C	I					C			C
Identifies site level risks associated with pandemic response.	R/A	I	I	I				I	C			C
Identifies and reviews site level triggers which would require escalation.	R	A/C	I/C						C			
Completes required site level pandemic plan audits and acts on results.	R/A	A/I	I/C	I				I/C	I/C			
Monitors audit results and actions.	R/A	I	I/C	I					R			
Develops tasks sheets for all clinical and non clinical departments to guide the day to day workflow in an outbreak (See examples)	R/A	I	I/C									
Provides pandemic response training to all staff and volunteers at the site.	R/A	I	I/C						I/C	I		

	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13
Establishes site-based mechanisms to review and inform implementation of IP&C measures. (e.g Audit)	A	I	I						I	R			
Completes IP&C audits.	R/A	I/C							I	I/C			
Identifies and provides recommendations for IP&C risks.	A	I	I						C	R			
Monitors residents' health status and reports atypical changes.	R/A	I	I						I	I/C			
Establishes physician coverage for PCHS in collaboration with SDO and PCH Medical Directors.	I/C	R/A	I	I									
At a provincial level, identifies service priorities and what services can be reduced.		C	I/C	R/A	R/A						C/I		
At a regional level, identifies services or portions of service that can be reduced.	I/C	R/A	I	I	I						I	C/I	
At a site level, identifies services or portions of service that can be reduced, including identification of critical and nonessential services based on resident's health and	R/A	I/C	I/C	I/C	I/C						I	C/I	R

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
functional status.														
Action staffing shifts at the site based on the priorities identified provincially, regionally and at the site level.	R/A	I	I/C	I									I	R
Identifies regional staff impacted by service reductions including classification, skill set, EFT available for redeployment.		R/A										I	C		
Identifies site staff impacted by service reductions including classification, skill set, EFT available for redeployment.	R/A	I	I/C									I		R
Coordinates the assignment of redeployed staff from a provincial perspective		C	C	C	C/I							R		
Coordinates the assignment of redeployed staff from a regional perspective												R	R	
Assist with coordination of redeployed staff - as a sending site.	R/A	I	I/C									R		R
Tracks expenses related to pandemic response (e.g. staffing, overtime,	R/A/I	R/A/I	I											

equipment, supplies)													
Identification and communication of a positive case(s)	R/A	I	I	I					I	I/C			
Declaration of an outbreak, in consultation with IP&C / Designate	I/C	I	I					I	R/A	C			
Implements Site Level Incident Command Meetings. Meeting frequency is determined by severity of outbreak; recommended daily.	R/A	I/A	I	I					I	C			
Implements Regional Level Incident Command Meetings. Meeting frequency is determined by severity of outbreak; recommended daily.		R/A	I	I	I				I	C			
Uses approved provincial scripts to communicate with staff and families.	R/A	I	I	I								I	I	R
Measures and monitors identified site level triggers	R/A	I/C/A	I/C	I						I			
Ensure and implement plans to meet client care needs during outbreak.	R/A	I	I/C	I									

Implements site level strategies to address any identified issues.	R/A	I	I/C											
Assist with coordination of redeployed staff - as a receiving site.	R/A	I/C	I/C	I							R			
Orientation and training of staff redeployed to the site.	A	A										I	R	R
Maintenance of time sheet for staff redeployed to the site, including submitting time sheet as per processes to ensure payment .	A												I	R/A
Manages case contacts and outbreak.	A	I	I/C	I					R	R				
Monitors residents' health status and reports atypical changes.	R/A								I/C	I				
Identifies and provides recommendations for IP&C risks.	A	I/A	I/C						R/C	R				
Continually review of critical and nonessential services based on resident's health and functional status.	R/A	I/A	I	I						I				
Escalation During an Outbreak														

HR Issues Identified.	R/A	C/I	C/I	I							I	I	R
Site Level strategies to address HR issues implemented.	R/A	I/A	I									I	R
Regional Level strategies to address HR Issues Implemented.	I/C	R/A	I	I	I						I	R	C
Provincial Level strategies to address HR Issues Implemented.	I	I/C	I/C	R/A	R/A						R	C	C
Resident Care Issues identified.	R/A	C/I	C/I	I									
Site Level strategies to address Resident Care issues implemented	R/A	I/A	I/C										
Regional level strategies to address Resident Care issues implemented	I/C	R/A	I										
Provincial level strategies to address Resident Care issues implemented	I	I/C	I/C	R/A	R/A								
Supply and resource issues identified.	R/A	C/I/A	C/I	I									
Site level strategies to address Supply and Resource issues implemented	R/A	I/A	I/C										
Regional Level Strategies to address Supply and Resource	I/C	R/A	I										

issues implemented														
Provincial Level Strategies to address Supply and Resource issues implemented	I	I/C	I/C	R/A	R/A									
IP&C Issues Identified.	A	C/I	C/I	I				I/C	I/C	R				
Site level Strategies to address IP&C issues implemented	A	I/A	I/C						I/C	R				
Regional Level Strategies to address IP&C issues implemented	I/C	R/A	I						R	I/C				
Provincial Level Strategies to address IP&C issues implemented	I	I/C	I/C	R/A	R/A			R	C	I				
Financial issues identified.	R/A	C/I/A	C/I	I										
Site level strategies to address financial issues implemented.	R/A	I/C/A	I											
Regional Level Strategies to address financial issues implemented.	I/C	R/A/C	I											
Provincial Level Strategies to address financial issues implemented.	I/C	I/C	C/I	R/A	R/A									

PANDEMIC STAFFING PLAN

It is important to have a pandemic staffing plan that can be readily utilized in the event of a pandemic. The plan must address:

1. How staff are made available:

   a. The process to identify those staff that have availability due to service reductions in their areas of work – whether partially or fully.

   b. Identify process to determine what movement can occur within a site/program to maximize resources and identifying the staff that:

      i. Could be reassigned and where.

      ii. What staff are not required at that site/program in the context of the pandemic.

   c. Identify other non-traditional resources that could be utilized in areas of need.

   d. Expedited hiring of staff for the period of the pandemic.

   e. Resources from other jurisdictions, i.e. federal resources.

2. Where the staff come from:

   a. Reassigned within the site/program.

   b. Redeployed from other areas.

   c. New hires (deployments from Pandemic Resource Pool - expedited hiring process utilized in a pandemic).

   d. Training:

      i. Identifying training and orientation requirements for staff being reassigned

      ii. Use of micro-credentials

   e. Collaboration with educational facilities to:

      i. Obtain access to students who may be willing and able to assist.

      ii. Develop required training such as micro-credentials.

   f. Collaboration with regulatory bodies to:

      i. Obtain access to members who may be willing and able to assist.

      ii. Assist with expediting temporary registration for retired professionals.

      iii. Identify scope of practice for existing and new required roles, i.e. who can conduct nasopharyngeal swabbing, who can immunize, etc.

   g. Media relations – call outs to the public including but not limited to retired professionals.

A pandemic staffing team needs to be set up to assist with pandemic staffing response. This can be modelled on the Provincial Redeployment and Recruitment Team (PRRT) that was set up in the Spring of 2020 in response to COVID19. Specific references to the existing process could be easily tailored for future pandemic situations. For ease of reference, the current pandemic staffing team – PRRT - and exiting processes are referenced throughout.

REQUESTING RESOURCES

If a site/unit/program/region require resources they contact the PRRT. Resources are requested using the resource request form: https://sharedhealthmb.ca/files/covid-19-resource-request-form.xlsx which is then sent to COVID19Recruitment@sharedhealthmb.ca

The resource request form is a simple and easy to use tool that could be utilized for future pandemics. This form provides the information that is required to identify the classification, required skill sets, the number required, where, when, and other information required to fill a resource need. This can be utilized for commonly used classifications such as Registered Nurses, Health Care Aides, Occupational Therapists, etc. as well as more specific requirements such as Infection Control Professionals (ICP, ICU Nurses, Medical Lab Technologists, or those that did not exist pre-pandemic, i.e. testing sites, immunization clinics, etc. It reduces the need for follow-up questions if other means to request resources are used thereby expediting the ability to meet resource requests.

IDENTIFYING AVAILABLE RESOURCES

REDEPLOYMENT

Staffing resources are finite. Where resources are required to meet needs in a specific area(s), services may need to be eliminated or reduced in other areas in order to free up those resources. This is a decision made by Health Incident Command (HIC) in collaboration with SDOs and other stakeholders taking into account impacts resulting from such a decision. HIC, programs/sites/units/regions, working in collaboration, determine which services can be reduced taking into account impact on the services in the region and/or province as a whole. Criteria is applied consistently to ensure standardization of staffing ratios. Once reductions are approved, the programs/sites/units identify the staff impacted (eligible for redeployment) as a result of the approved service reductions.

Programs/sites/units provide the PRRT with the list of employees or positions that are eligible for redeployment using the following spreadsheet: https://sharedhealthmb.ca/files/covid-19-staff-eligible-for-redeployment.xlsx . The redeployment spreadsheet is sent to: COVID19Recruitment@sharedhealthmb.ca

The COVID19Recruitment mail box is monitored by the PRRT Intake team. The information is tracked for monitoring and reporting purposes. Members of the PRRT Recruitment and Deployment teams have access to this information which is required in order to fill resource requests.

The redeployment spreadsheet was created to identify employees impacted by a service reduction and includes detailed information with respect to each employee including but not limited to: name, classification, EFT, location of work, union, manager, skill set, other positions held, contact information, etc. The redeployment spreadsheet provides all information required to identify if an employee(s) can be redeployed to area(s) of identified need and the information required to effect the redeployment.

In collaboration with HIC and clinical leadership, the PRRT reviews the redeployment spreadsheet for the appropriate skill set to meet the resource needs. Where there is a match between available resources and identified needs, the PRRT sends the Redeployment Notification to the Receiving and Sending Sites. This includes all information required to process the redeployment including the Redeployment Checklist for the Receiving Site which identifies the steps to take to determine the rotation(s) required to fill resource needs, identifies site specific onboarding activities, and contains a checklist of what the Receiving Site needs to consider: site access, parking, site/unit specific orientation, who the redeployed staff will report to, specific access the employee will require (building, units, med room, EMR, PYXIS, computer, etc.) and requests the name and contact information for the timekeeper and the cost centre this will be charged to.

PRRT role (not all inclusive):

- Ensure all required information is included in the spreadsheet
- Check to see if employee has alternate employment if not noted on the spreadsheet
- Notify manager where employee has alternate employment and obtain information re schedule to avoid unintended impacts to the unit/site/program
- Ensure communication flow between Receiving and Sending Sites
- Assist with any issues that arise
- Provide required information to affected sites; ensure process is followed for appropriate tracking, pay, and reporting
- Coordinate return of redeployed employees from Receiving Site

Summary of Process:

- PRRT sends Sending Site HR Director and Receiving Site contact list of employees eligible for redeployment.
- Sending Site HR Director connects with Receiving Site to obtain schedule.
- Sending Site HR Director connects with redeployed employee's manager and discusses the redeployment.
- Sending Site HR Director or manager connect with employees eligible for redeployment requesting volunteers first. If insufficient volunteers, employee(s) can be redeployed without agreement. It should be noted that future pandemics would

require agreement with the applicable unions in order to redeploy employees involuntarily.

- Sending Site HR Director informs Receiving Site contact and PRRT.
- Sending Site HR Director informs applicable union(s) of employees that have been redeployed.
- Receiving Site Contact tracks hours worked by re-deployed employee and provides to Sending Site so Sending Site can pay salary.

There is no interview. The Receiving site cannot decline the contact if qualifications/skill set are met.

Employees can be partially redeployed. This can be done in several ways:

Example 1: 50% reduction in work, one staff. A 1.0 EFT can be redeployed for 0.5 of their EFT.

Example 2: 50% reduction in work. Two staff; both 1.0s doing required work. Where operationally feasible, duties can be bundled and reassigned so that only one of the 1.0 EFTs is doing the required work previously done by both and the other 1.0 is redeployed.

Example 3: 50% reduction in work, ten staff. Bundle/reassign the work so that five staff can be redeployed for their full EFT rather than redeploying 50% of the EFT of all the staff.

NOTE: **HIC determines what classification of resources can be redeployed and where they are required. Similarly, Incident Command determines when services resume/increase and needs are reduced at the Receiving Sites to be returned to the Sending Sites. PRRT working in collaboration with HIC and the Sending and Receiving Sites coordinates the process.**

Once staff have been identified for redeployment from the Sending Site to the Receiving Site, the PRRT will send a Redeployment Notification to the Receiving and Sending Sites which includes the information they need in order to manage their redeployed staff.

When redeployed staff are being returned to the Sending Site, communication occurs between the Sending and Receiving Site to facilitate the return of the redeployed staff. The PRRT is informed to ensure appropriate tracking. If the Receiving Site still has a need for resources then the PRRT would review the redeployment list to obtain suitable alternate resources.

EXPEDITED HIRING PROCESS

It is not possible to meet all staffing needs through the redeployment process. An expedited hiring process is required to attract additional resources. For COVID19, an

expedited hiring process was established for recruitment and hire of staff to the Shared Health COVID19 Casual Pool.

Mass postings or individual postings are done. Mass postings allow for the posting of multiple positions in a single posting, not specifying a site, to develop a pool of applicants for recruiting (e.g. call for Health Care Aides). Postings can also be site specific e.g. Alternative Isolation Accommodation. Qualifications do not need to be limited to a specific classification, e.g. LPN, RN, OT, PT, etc. and identify that the successful applicant would be paid at their classification rate of pay and come under the applicable Shared Health Collective Agreement for their classification.

Communications to educational institutions and regulatory bodies are sent advising of available opportunities and for dissemination through mailouts and newsletters to students, former students, members. Information on prioritized needs and the means to express interest in them are provided.

Before a position can be filled, a position must be created in SAP (PCN). Compensation Services and Organizational Management use existing Job Profiles for these positions. If a new COVID 19 Casual Pool resource category which does not currently exist is required, Compensation Services and Organizational Management will, with PRRT input, create the job description or job posting used to build the job profile for posting and create a salary scale if one does not exist. A Job Code (classification) is created. This will determine the PA (Personnel Area or Site) and PSA (Personnel Sub Area or Union Grouping). Once these are established, this information is provided to Finance with the request that PCN(s) be created.

Some positions may require a streamlined telephone interview to determine suitability vis a vis qualifications/skill set while others do not (e.g. interviews are not required for Entry Point Staff Screeners). Positions that require current registration with an applicant's regulatory body are checked prior to an offer being made, e.g. RNs must be registered in order to work as RNs.

PRRT makes the decision to hire, verbally offers the position to the applicant(s), and completes the Position Budget Request spreadsheet for the selected applicants for expedited load of employee information into SAP. This is the information submitted to HR Shared Services (HRSS) to hire applicants and includes legal name, address, date of birth, social insurance number, PCN, salary, start date.

HRSS creates the offer letter using the COVID19 Casual Pool standard offer letter. The offer letter that they receive and sign attests that they do not have a criminal record and are not on the Child Abuse or Adult Abuse Registries. If the applicant has a criminal record then this is escalated to the PRRT Director or designate. The PRRT would not proceed with the hire of an applicant on the Child Abuse or Adult Abuse Registries. The offer letter also requests verification of educational qualifications.

HRSS sends out the onboarding information to the new hire. Casual Pool Employment Preparation Steps are sent to the Casual Pool Employee with their Casual Pool offer letter. This includes:

1. When/how to expect their Login Credentials.

2. How to obtain their Photo ID badge.

3. Required Learning Management System (LMS) courses totaling 2.50 hours:

   a. Fire Safety Code Red (30 minutes)

   b. Hand Hygiene (15 minutes)

   c. PHIA (45-60 minutes)

   d. WHMIS (30 minutes)

   e. Personal Protective Equipment (15 minutes)

      The new Casual Pool staff are paid for 2.50 hours to complete these required courses.

4. Notification that online onboarding is required and to expect further instructions received from healthcarecareers@wrha.mb.ca . This is all done online, including providing an electronic signature on the forms. The employee is asked to do the following before the first day of work:

   a. Complete some benefit enrollment forms and tax forms.
   b. Provide payroll deposit information.

   c. Read key regional policies.

PRRT requests the network credentials for the Casual Pool staff and emails the new Casual Pool staff their network ID with a reminder to complete the LMS training. PRRT checks the new hire's progress with completing the LMS training.

PRRT sends the Deployment Notification to the Receiving Site. The Deployment Notification is customized for the Receiving Site:

1. PRRT inserts the appropriate Notification content for Casual Pool hires. For example, these staff may not have a set schedule. Note: casual term positions have a set rotation/schedule.

2. Casual Pool staff are Shared Health staff (on SAP).

3. Employee Welcome information has been gathered from the Receiving Site that contains location, Receiving Site contact, when and where to report to for work. Alternatively, the Receiving Site contact can be asked to connect directly with the Casual Pool employee and review what is required for their first day.
4. If the employee has not completed their LMS training, PRRT includes information for the Receiving Site to ensure the training is completed on their first shift.
5. If the employee has completed their LMS training, PRRT includes information for the Receiving Site that they will see this reflected on the timesheet.
6. PRRT provides the Receiving Site with the timesheet for the new hire, inserting employee name, ID number, Receiving Site contact information for invoicing, and Sending Site Timekeeper contact information:
   Covid-19CentralTimekeeping@sharedhealthmb.ca

7. Reminds Receiving Site that timesheets are to be submitted to the Sending Site (link above) on a weekly basis.

PRIORITIZING REQUESTS

During a pandemic, the requests for resources can far outstrip the available supply. Given finite staffing resources, it is important for requests to be prioritized. This needs to be determined in conjunction with Health Incident Command (HIC) with a clear mechanism to identify when this situation occurs, the impacts, and provide a means of addressing same.

Process

1. Summary of resource requests sent by PRRT to HIC Operations Chief including:
   a. Number of overall resource requests.
   b. Number of overall resources requested:
      i. By classification.
      ii. Skill set.
      iii. Sector.
      iv. Region/Site/Unit(s).
2. Summary of available resources available through redeployment:
   a. By classification.
   b. Skill set.
   c. Sector.
   d. Region/Site/Unit(s).
3. Summary of available resources in the COVID19 Resource Pool.
   a. By classification.
   b. Skill set.
   c. Sector.
   d. Region/Site/Unit(s).
4. HIC to provide guidance and direction on which requests are priority.

PRRT also needs to communicate with resource requestors to indicate what resources are potentially available and provide an estimate of how quickly they can be met and to what extent.

TRIGGERS FOR PRIORITING PCH REQUESTS

The staffing plan sets out three situations/scenarios/levels which set out progressively more challenging staffing situations, the service delivery options and the staffing

strategies to address each situation. It is acknowledged that a situation can change very quickly requiring a flexible proactive approach.

Medical and Infection Prevention and Control Triggers are included in the service delivery information in the scenarios. For ease of reference the medical and IPC triggers are:

TRIGGERS FOR ENHANCED MD/NP PRESENCE IN A DECLARED PCH OUTBREAK

Enhanced presence of MD/NP in a PCH will occur if/when:

1) One resident (not staff) is confirmed as a positive case at which time on site MD/NP presence will increase to three times / week

2) Three or more residents (not staff) are confirmed as positive cases at which time on site MD/NP presence will increase to daily visits.

To achieve this level of rapid response to changing needs in the PCH, there will need to be a coordinated and integrated approach between the provincial LTC/PCH Leads (administrative and medical), the Regional LTC/PCH Leads (administrative and medical) and the Site LTC/PCH Leads (administrative and medical). Other potential "triggers" to enhance MD/NP presence in the PCH may be considered through these provincial, regional, site leads and the respective incident command structures developed to coordinate care.

The ramping up of services will be defined as below. The ramping down of services will be dependent on multiple factors determined by the provincial, regional and site leadership.

TRIGGERS FOR ENHANCED INFECTION PREVENTION AND CONTROL (IPC) PRESENCE IN A DECLARED PCH/LTC OUTBREAK

Regular presence of the site ICP on the units in their facility is a basic expectation, as is an increased presence on units affected by cases of communicable diseases and outbreak activity. In accordance with current staffing models and staffing levels, regular presence of regional IPC in LTC facilities is the standard. Priorities are set according to need, based on factors including site and regional IPC capacity, nature of the outbreak and degree of control.

With sufficient regional resources in place, enhanced IPC presence in a LTC facilities/PCH will occur if/when:

1. One resident (not staff) is confirmed as a positive case at which time on site and affected unit IPC presence will preferably increase to daily presence with three times per week minimum. Consultation with regional IPC shall occur. One resident case may/may not require regional IPC onsite presence; assessment of the situation is required to determine the need. An after-hours support structure is triggered via the Site LTC/PCH Leads to the Regional LTC/PCH Leads.

Regional LTC/PCH Operational Leads/designate facilitate after hours IPC support coordinated/identified in advance via the region.

2. There are two or more confirmed resident cases (not staff). On site and affected unit IPC presence to increase to required daily visits. Consultation with regional IPC shall occur; assessment of the situation is required to determine the need for onsite regional IPC presence. An after-hours support structure is triggered via the Site LTC/PCH Leads to the Regional LTC/PCH Leads. Regional LTC/PCH Operational Leads/designate facilitate after hours IPC support coordinated/identified in advance via the region.

To ensure the appropriate level of support and rapid response to changing needs in the LTC facilities/PCHs, a coordinated and integrated approach between Regional LTC Leadership (administrative and medical) and the Site LTC/PCH Leads (administrative and medical) is required. Other potential "triggers" to enhance IPC presence in the LTC facilities/PCH may be considered through these provincial, regional, site leads, and the respective incident command structures developed to coordinate care.

The ramping up of services will be defined as below. The ramping down of services will be dependent on multiple factors determined by the provincial, regional and site leadership in consultation with relevant levels of IPC.

IMPORTANT NOTE:

The scenarios below are intended as a general guide; other factors/considerations need to be taken into account. Each scenario identified below must be viewed with the following factors in mind which may alter the staffing strategies requiring elevation of the need to meet the staffing challenges. If other factors identified below exist, a 5% vacancy may require response at a scenario level higher than 1.

Factors

1. The size of the PCH. A smaller PCH may have the same impacts at a 5% staffing vacancy that a large PCH would not have until they are at 10% or more.

2. Geography. Similar to size, remoteness and accessibility to a PCH will exacerbate staffing challenges and may increase the challenges in obtaining required resources.

3. Staffing vacancies include all staff: Managers, Nurses, HCAs, Allied Health, Support Staff (Dietary, Housekeeping, etc.). Vacancies in any classification will have an impact on the overall functioning of the PCH.

4. Vacancies includes vacancies regardless of cause: personal or family illness due to the pandemic or any other cause, personal isolation, child/elder care, leaves of absence, unfilled vacant positions.

5. Number of staff currently sick due to the pandemic and/or increasing volume of sick calls including review of close contacts and those awaiting test results.

6. Public Health/ Medical Officer of Health direction for all staff to undergo asymptomatic testing given an uncontrolled outbreak, which may result in additional staff testing positive and having to isolate.

7. Infection Prevention and Control and/or Public Health/Medical Officer of Health direction for asymptomatic resident testing given an uncontrolled outbreak, which may result in additional residents testing positive and increased resident care requirements and additional donning and doffing PPE requirements.

8. Any reduction in staffing levels that can't be resolved using normal processes (e.g., overtime, agency staff, PRRT).

9. Level of overtime and/or mandating.

10. Staff to resident care ratio (e.g., 3.6 hours of care per resident day or above is not met within nursing).

11. Inability to schedule staff to meet minimal staffing guidelines or meet outbreak requirements within any department (e.g., enhanced infection prevention and control requirements, increased housekeeping requirements; isolation requirements for residents; increasing reporting requirements).

12. Acuity of the residents within the facility.

13. Outstanding COVID-19 resident swabs (waiting on number of tests/swabs pending).

14. Point in disease trajectory (day 2 vs. 10); should be number of residents exposed to facilitate planning sooner.

15. Number of reported cases in surrounding community.

16. Staff reporting or demonstrating feelings/expression of fatigue, feeling overwhelmed, etc.

17. Ability to access designated family caregivers for support.

18. Ability to access volunteers.

19. Ability to support regular communication with families.

Staffing Triggers

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
1	Staffing challenges and/or staffing impacts such as gaps in schedules combined with inability to fill some vacant positions. Site working short, increase in overtime. Reduction in staffing levels under 5%. May have a site with 1 or 2 possible positive residents or staff.	. • PCHs must provide as much regular care and resident services as possible including nursing, allied health, recreation, medical care, personal care supports, housekeeping and laundry. • Enhanced presence of MD/NP in a PCH will occur if/when one resident	• Offering additional shifts to part time staff. • Offering additional shifts to casual staff. • Offering additional shifts for longer period of time (e.g. 3 months instead of 6 weeks). • Offering overtime. • Mandating overtime. • Underfilling shifts (e.g. two HCAs for vacant nurse shift).

| | | (not staff) is confirmed as a positive case at which time on site MD/NP presence will increase to three times / week.

• One resident (not staff) is confirmed as a positive case at which time on site and affected unit IPC presence will preferably increase to daily presence with three times per week minimum. Consultation with regional IPC shall occur. One resident case may/may not require regional IPC onsite presence; assessment of the situation is required to determine the need.

• An after-hours support structure is triggered via the Site LTC/PCH Leads to the Regional LTC/PCH Leads. Regional LTC/PCH Operational Leads/designate facilitate after hours IPC support coordinated/identified in advance via the region. | • Utilizing work short protocols.
• Combining low EFTs.
• Offering higher EFTs (EFT Increase Form).
• Changing shift descriptions for hard to fill shifts (e.g. changing N shift to D/E or D/N where feasible).
• Overscheduling during high sick call shifts.
• Standby staffing for peak periods – can have combo of 8s and 12s.
• Building stats into the rotation.
• Recruiting into existing vacancies.
• Utilizing agency.
• PCH reaches out to its previously retired staff willing to work.
• Utilizing voluntary redeployment of nurses and HCAs.
• Filling vacant roles from pandemic Resource Pool.
• To achieve enhanced rapid response presence of MD/NP/IPC to changing needs in the PCH, there will need to be a coordinated and integrated approach between the provincial LTC/PCH Leads (administrative and medical), the Regional LTC/PCH Leads (administrative and medical) and the Site LTC/PCH Leads (administrative and medical).
• Other potential "triggers" to enhance MD/NP/IPC |

			presence in the PCH may be considered through these provincial, regional, site leads, and the respective incident command structures developed to coordinate care. • The ramping down of services will be dependent on multiple factors determined by the provincial, regional and site leadership in consultation with relevant stakeholders.

2	Increased staffing challenges and/or staffing impacts due to 1-5 positive staff and/or residents in 1-5 PCHs in a given region. Reduction in staffing levels by 5-10%. Difficulty staffing those PCHs due to staff required to self-isolate, increased sick calls, and increased reluctance of staff from pandemic Resource Pool to accept assignments in the impacted PCHs. PCH working short, increase in mandated overtime.
	
	PCH Operators in consultation with regional PCH leadership will assess the priority areas of services and engage in planning and responding with appropriate support.
		PCHs must provide as much regular care and resident services as possible, identifying which services can potentially be cancelled, postponed, or reduced based on available resources and resident needs. Visitor restrictions in place. Affected PCHs at Level Red.
		• May modify (reduce/ cancel) social and recreational activities, rehabilitation services, other programming (e.g. support with virtual visits etc.) and reassign staff to assist with other necessary care.
		• PCH respites and admissions are suspended.
		• There are two or more confirmed resident cases (not staff). On site and affected unit IPC presence to increase to required daily visits. Consultation with regional
			• Utilize staffing strategies identified in Scenario 1 and:
			   ○ Where activities/services are reduced or cancelled, reassign those staff to areas of need (e.g. Recreation staff can assist HCAs).
			      ▪ Provide training as required.
			• Utilize clinical management staff.
			• Utilizing voluntary redeployment of nurses and HCAs.
			• Filling vacant roles from pandemic Resource Pool
			• Outreach to educational institutions.

		IPC shall occur; assessment of the situation is required to determine the need for onsite regional IPC presence. • An after-hours support structure is triggered via the Site LTC/PCH Leads to the Regional LTC/PCH Leads. Regional LTC/PCH Operational Leads/designate facilitate after hours IPC support coordinated/identified in advance via the region. • If three or more residents (not staff) are confirmed as positive cases at which time on site MD/NP presence will increase to daily visits.	
3	Increased staffing challenges and/or staffing impacts due to 6-15 positive staff and/or residents in 6-15 PCHs in a given region. May have resident death(s). May be outbreaks in another region(s). Reduction in staffing levels by 10-20%. Increased difficulty safely staffing those PCHs due to staff required to self-isolate, increased sick calls, and minimal or no ability to provide staff from pandemic Resource Pool due to reluctance to accept assignments in the impacted PCHs and/or lack of available qualified	PCHs will need to continue to prioritize services and determine which additional services will need to be cancelled, postponed, or reduced based on available resources and resident needs. Visitor restrictions in place. Affected PCHs at Level Red. Similar to Scenario 2 and: • Linens may be changed only when wet or soiled at a minimum of every x (e.g.10) days. • Beds would be clean, however not necessarily be "made" as per usual expectations. • Resident personal clothing will be worn for 2 days unless wet or soiled	• Utilize staffing strategies identified in Scenario 2 and: o Seek exemption from 14-day restriction between working at PCHs to redeploy staff from one PCH to another (e.g. Site A with sufficient staffing, redeploys staff to positive site B). • Utilizing voluntary redeployment including alternate care providers in addition to nurses and HCAs. • Call out to SDOs identifying areas of current and anticipated need and requesting staff available for redeployment.

	staff. Increase in mandated overtime. PCH Operators in consultation with regional health system leadership will assess the priority areas of services and engage in planning and responding with appropriate support. Collaboration between different sectors in the region (Acute Care, Community, PCH etc.) is required	prior to sending for laundering. • Prioritize housekeeping services for resident areas. Administrative areas will be cleaned by housekeeping less frequently or not at all except in units with high prevalence of dementia where all surfaces including staff areas should be considered high touch. • Tub baths may be suspended, and residents only provided with sponge baths. • Dietary may resort to an Emergency Plan meals and menu. • Communication with family may change or decrease in frequency. i.e. general e-mail update, and resident specific updates only as required or resident condition changes.	• Mandatory redeployment within the region. • Fill vacant roles with alternate care providers from pandemic Resource Pool. • Outreach to educational institutions.

4	Staffing Crisis (staffing levels reduced by 20-30%) during an outbreak; multiple sites may be impacted.
	Increased staffing challenges and/or staffing impacts due to more than 15 positive staff and/or residents in 15 or more PCHs. Resident death(s). Outbreak in another region(s). Inability to
		PCHs will need to continue to prioritize services and will need to cancel, postpone, or reduce non-essential services.
		Personal Care Home leaders in consultation with regional health system leadership will assess the priority areas of services and engage in planning and responding with appropriate support.
			Same as 3 and:
			• Mandatory redeployment within the region.
			   o Consider staff incentives to go to remote areas (accommodation, travel, possibly additional compensation).
			   o Voluntary redeployment across regions.

	safely staff the impacted PCHs due to staff required to self-isolate, increased sick calls, and inability to provide staff from pandemic Resource Pool due to reluctance to accept assignments in the impacted PCHs and/or lack of available qualified staff.	Collaboration and coordination on a provincial level required to assess the priority areas of services and engage in planning and responding with appropriate support. • Where appropriate, implement Rapid Response/SWAT team concept – moving staff from other programs to PCHs to ensure sufficient staffing to provide safe care in PCHs. • SDOs in consultation with HIC will assess the priority areas of services and staff across regions and sectors. • Implement alternate models of care. More nurses will be required due to frequent nursing assessments and interventions such as medication administration that cannot be done by other disciplines. • If nursing services are reduced to those necessary to prevent adverse consequences to the residents and which can only be done by a nurse, it is necessary to then identify who can do the non-essential nursing services. Some may be done by HCAs, some by Recreation, Allied Health etc. • Provide education and training for staff where	• Call outs for former health care workers in the community/region/province. • Accessing other providers: ERS, medical offices, dental offices etc. where feasible to do so and provide training. • Call out for volunteers to assist with functions requiring minimal training, i.e. housekeeping, laundry.

		scope of practice is enhanced including professional and support staff e.g. Allied Health and Health Care Aides. • Canvass with families the possibility of taking healthy residents' home with Home Care, ensure they understand the risks and ability to manage at home. • Consider utilizing volunteers to assist with functions requiring minimal training, i.e. housekeeping, laundry. Ensure volunteers receive proper orientation and training including IP&C training.	
5	Staffing Crisis (staffing levels reduced by more than 30%) during an outbreak; multiple sites may be impacted. Increased staffing challenges and/or staffing impacts due to more than 15 positive staff and/or residents in 15 or more PCHs in multiple regions. Resident deaths in multiple PCHs. Inability to safely staff the impacted PCHs.	Collaboration and coordination on a provincial level required. Implement Rapid Response/SWAT team concept – moving staff from other programs to PCHs to ensure sufficient staffing to provide safe care in PCHs. SDOs in consultation with HIC will assess the priority areas of services and staff across regions and sectors. Government may consider issuing an Emergency Order granting temporary amendments to the relevant legislation and suspending	Same as Scenario 4 and: • Mandatory redeployment across regions. • May require military assistance.

		collective agreements so that SDOs are able to take all reasonable steps necessary to address the staffing issues which may arise in PCHs due to the pandemic.	

Roles & Responsibilities of Medical Leadership & Medical Staff during a Pandemic/Serious Outbreak

Serious Outbreak

Definition – Infectious Disease Severe Outbreak

An infectious disease with the following traits should be considered a severe outbreak:

1. Easily transmissible (likely respiratory, but could be through contact or food); AND

2. Low levels of natural or acquired immunity in the population; AND

3. Likely to cause severe outcomes in the population; AND

4. At least one of:

   a. No/Limited medical interventions for prophylaxis; AND/OR

   b. No/Limited medical interventions for treatment

Roles and Responsibilities

LTC/PCH Regional Medical Lead (or designate)

The role of the LTC/PCH Regional Medical Lead during a pandemic/serious outbreak:

1. Work with provincial and regional counterparts and leads to plan for a coordinated and standardized approach to a serious outbreak.
2. Work closely with Provincial and Regional Medical Officers of Health/Public Health, Infection and Prevention Control and Occupational Health as well as Shared Health to develop supporting processes, guidelines, and communication across the LTC/PCH continuum as information changes during a pandemic.
3. Liaise with all LTC/PCH sites in the Service Delivery Organization (SDO) to support a coordinated approach to the outbreak if needed.

4. Work with the appropriate LTC/PCH leadership in the SDO and participate in Regional Incident Command meetings.

5. Meet and support LTC/PCH Site Medical Leads as well as LTC/PCH Administrative Leads on a regular basis during a serious outbreak/pandemic. This may be most efficiently done by attendance at the Site Incident Command meetings.

6. Will be available (or designate) 24/7 to answer questions from medical staff (MD/NP) from sites experiencing an outbreak.

7. Supports the development of, along with provincial Infection Prevention and Control (IPC) medical and program leads, an integrated Infection Prevention and

Control Program for Long-Term Care for the region, while standardizing ICP practices, where appropriate, in the Province of Manitoba.

8. Supports the maintenance and implementation of an integrated Infection Prevention and Control Long-Term Care Program encompassing PCH Site Medical Leadership; PCH Medical Staff and Regional and PCH Infection Prevention and Control staff.

9. Supports Regional and Site PCH/LTC Medical Leads in addressing Infection and Prevention and Control specific issues and serves to connect regional and site level medical leads to provincial Infection Prevention and Control Leads where appropriate.

10. In collaboration with the Regional Medical/Specialty Leadership team help establish and maintain an IP&C program organization structure consistent with the Shared Health Provincial Medical specialty governance structure.

LTC/PCH Site Medical Leads

The role of the <u>LTC/PCH Site Medical Lead</u> during a pandemic/serious outbreak:

1. Develop a schedule, based on pandemic/outbreak guidelines and policies, for medical staff presence (physicians/NPs) within the LTC/PCH setting to meet the needs of the residents, until such time as the outbreak is declared over.

2. Attend Site Incident Command meetings and work with the LTC/PCH Site Administrator in coordinating the needs of the LTC/PCH residents during a serious pandemic outbreak.

3. Support LTC/PCH physicians/NPs on a regular basis during a serious outbreak/pandemic for the purposes of staying in touch and informed as well as offering teaching/learning opportunities.

4. May be asked to be part of an on call medical leadership group (along with the LTC/PCH Regional Medical Lead to be available 24/7 to answer questions from medical staff (MD/NP) from sites experiencing an outbreak.

5. Your role as a Site Medical Lead is twofold: you are a resource and leader for your PCH and you are also the guide for your staff of physicians and nurse practitioners who provide the care on site.

Outbreak Escalation Triggers

With the first positive resident of an outbreak, on site visitation by MD/NP is expected to increase to 3x/week.

1. If there are more than 3 residents affected, then daily visits are expected.

2. Is there an explicit plan for a handover of care after a period not longer than 14 days of onsite care? A "ramp down" strategy?

LTC/PCH Site Medical Lead Pandemic/Serious Outbreak Checklists

The following checklists are meant to provide a review of current practice and expectations for the LTC/PCH Site Medical Lead.

CHECKLIST 1 - LTC/PCH Site Medical Lead as a resource to the PCH:

1. Keep up to date on current LTC Infection Prevention & Control Measures.

2. Encourage vaccination of all staff including MDs/NPs.

3. Speak to your LTC/PCH Site Administrative Lead to determine your involvement in the Pandemic/Serious Outbreak Planning
   • Does your site have the ability to do hypodermoclysis?
   _____

   • How will you be notified when an outbreak occurs?
   _____

   • How is your LTC/PCH managing outbreaks (e.g. cohorting)?
   _____

   • Is there a clear written contingency plan if there are physician/clinician coverage issues expected?
   _____

CHECKLIST 2 - LTC/PCH Site Medical Lead as a leader to the Attending MDs/NPs:

1. Speak to every MD/NP that works at your site.
   • Do they have barriers or risks that would prevent them from attending in person in the event of an outbreak?
   _____

   • What is their time commitment to the LTC/PCH in the event of an outbreak?
   _____

2. What is your outbreak plan for MD/NP coverage?
   _____

- With the first positive resident of an outbreak, on site visitation by MD/NP is expected to increase to 3x/week.

- If there are more than 3 residents affected, then daily visits are expected.

- Is there an explicit plan for a handover of care after a period not longer than 14 days of onsite care? A "ramp down" strategy?
  _____

3. Do you need additional MD/NP resources if you have an outbreak?
   _____

4. Discuss/prepare with the LTC/PCH Regional Medical Lead so that contingency planning can be prepared in advance.

5. If you have MDs/NPs that are unable to assist with outbreak response, will you (circle your selection):

   a. reduce their workload or

   b. temporarily replace them or

   c. can they support the clinical demands of the medical staff providing on site care?

6. Discuss with the LTC/PCH Regional Medical Lead so that recruitment planning can occur.

7. Work with the MDs/NPs to have the staff focus on tasks that assist in streamlining resident care during an outbreak:

   - QMRs with a focus on de-prescribing and simplifying medication passes and medication frequency regimens

   - Discuss ACP status with residents/POA.

   - Review current status and wishes in the event the resident gets seriously ill. Involve family where appropriate.

   - Get clear understanding of level of care:

     - Do they want to transfer to hospital if declining due to (outbreak identifier)?
       _____

     - Do they prefer to maximize on site management and transition to palliation if not improving?
       _____

- Do they want intubation/CPR/etc. if declining)?

_____

8. If possible, cohort individual MD/NP's clinical work to a unit/floor rather than throughout multiple floors/units in a PCH. This encourages better teamwork and less movement between multiple units for each MD/NP.

9. Consider going to a single on-call provider per PCH afterhours call model. Rather than all MDs/NPs taking calls afterhours for their own residents, move to a model where one provider is on call for the entire PCH. This reduces on-call burnout and provides a single clear contact for on-call issues.

10. Ensure that all MDs/NPs continue to contact their associated Emergency Department for any transfers out from the PCH. If possible, discuss these at Regional Incident Command meetings if time allows (I.e. will not delay the timely provision of care).

Outbreak Management Information

LTC/PCH Medical Staff (MD, NP, PA) - Pandemic/Serious Outbreak Information

This information has been prepared to be provided to physicians and nurse practitioners at the time they are participating in care at a PCH that is in a pandemic/ serious outbreak situation.

Occupational Health Contact Information

Please contact the physician occupational health resource as per SDO/provincial protocol.

Contact Occupational Health for contact tracing and your need to be tested or isolate related to the outbreak at the personal care home. This includes weekends and holidays if necessary.

Name_____

Title_____

Work phone _____

Cell phone (text or call)_____

Email _____

Infection & Prevention Control (IPC) Contact Information

Please contact the Infection & Prevention Control contact person as per SDO/provincial protocol.

Name_____

Title_____

Work phone _____

Cell phone (text or call)_____

Email _____

MOH/Public Health Contact Information

Name_____

Title_____

Work phone_____

Cell phone (text or call)_____

Email _____

Outbreak Communication

Incident Command Committee Meetings: There is a formal site committee structure immediately convened to coordinate the site level and in sync with a regional response to outbreaks at personal care homes.

- You will be invited to the Site level Incident Command Meetings. You will help identify issues/areas of concern brought up at the site level that require escalation through the LTC/PCH site leadership (LTC/PCH Site Medical Lead or Site Administrator).
- During a pandemic/serious outbreak, your involvement through regular site meetings will be essential.
- Where available, the outbreak specific Terms of Reference will outline the roles and an agenda for these meeting.
- If you are not able to attend an Incident Command Meeting please contact the LTC/PCH Site Medical Lead or the LTC/PCH Site Administrator for anything you need to report and review the minutes following the meeting.

Email: Email is the primary mode of communication for invitations to Incident Command Committee meetings, meeting minutes and copies of communications with staff and families.

- **Important:** Please provide the LTC/PCH Site Administrator with the email address you check regularly, including after hours. *Where applicable, the use of a SDO approved email is the preferred mode of communication as per the Rules & Regulations 7.5.1*

Virtual Meetings: The incident command meetings usually occur by Microsoft Teams (or other) App. It is very helpful if you have a microphone and webcam. To use your phone or tablet you will need to download the Microsoft Teams (or other) App.

Payment: You can be remunerated for your participation in the Incident Command

Meetings depending on your payment model. There is a medical remuneration form you can fill out with the (insert date/year) rate. Alternatively, contact your Medical Administration / Services Department (insert email) to discuss the appropriate payment process.

LTC/PCH Medical Lead Contact - Info for Assistance

LTC/PCH Regional Medical Lead (or designate) Contact Info

Name_____

Title_____

Work phone

_____

Cell phone (text or
call)_____

Email

_____

LTC/PCH Site Medical Lead Contact Info

Name_____

Title_____

Work phone

_____

Cell phone (text or
call)_____

Email

_____

General Outbreak Management

Resident symptom surveillance and testing guidance: The guidance for symptoms suggestive for (outbreak identifier) in the LTC/PCH setting is broader than that for the general public.

- An outbreak code may be required to be included on the requisition sent with the swab.

Outbreak checklists: Refer to the appropriate guiding checklist for the outbreak in question at the LTC/PCH.

On site medical care: When there is a surge in residents with (outbreak identifier), an increase in on site medical care is needed (daily during the intense phase of the outbreak).

- Special Pandemic/Outbreak tariffs may be available for the increased presence on site. Check with your SDO Medical Administration Services (insert email) for the details including the remuneration form.
- It is strongly recommended that a plan for handover of on-site medical coverage be scheduled at approximately day 14, if not sooner.
- In the case of an unexpected absence from site due to symptoms requiring isolation at short notice dialogue with local colleagues and the LTC/PCH Site Medical Lead should occur to discuss coverage.
- If there are any concerns that coverage is not available with local providers, please contact the LTC/PCH Site Medical Lead as soon as possible so that alternatives can be explored.

PPE donning and doffing: The personal care home will supply you with appropriate PPE.

- If there are circumstances in which an N95 mask is needed you will have to have been fit tested within the last 2 years and your name tag will indicate the brand of mask for which you have been tested.
- Ensure that the brand of mask is on hand (discuss with LTC/PCH Site Administrator)
- You are encouraged to ask someone to buddy with you for donning and doffing of PPE.
- Infection Prevention & Control has suggested the following videos and information for review of donning and doffing:
  - Donning   (link)
  - Doffing   (link)
  - Point of care risk assessment: link

Review of Goals of Care: Transfer to hospital and Intensive Care

Educational material may be available to support a "Serious Illness Conversation" in the context of (Outbreak identifier): **i.e.:** https://www.youtube.com/watch?v=-3LfeaJWS8A

- Site staff should be able to provide you with a list of residents who have previously expressed a wish for active medical management including transfer to hospital and anyone who has an Advanced Care Plan that includes Resuscitation (R).
- For residents wanting hospital and intensive care treatment, the goals of care need to be reviewed at the time an outbreak is declared and with changes in clinical status. This is essential to understand the resident wishes in more detail. Changes in status triggering review include but are not limited to the resident testing positive for (outbreak identifier) and developing symptoms requiring (oxygen therapy, rehydration).
- If a resident and/or their substitute decision maker has indicated they want intensive treatments **it is important to state and document that these options require telephone consultation with an intensive care specialist and/or the hospital admitting physician. These consultants may decide, at the time that the resident will not benefit from those treatments and those intensive interventions should not be offered.** This is dependent on the resident's underlying comorbidities and frailty as well as their clinical status at the time off site treatment is being discussed.

Pandemic/Outbreak Template for Standard Orders

Pandemic/Outbreak Template for Standard Orders

(See Appendix A for example)

    a. **Supplemental O2:**

    b. **IV and subcutaneous fluid for treatment of dehydration:**

    c. **Protected Code Blue PCH:**

    d. **Cohorting guideline:**

    e. **IPC discontinuation of precautions:**

    f. **Medication streamlining:**

    g. **Death of a suspect/confirmed PCH Resident:**

Education

(Appendix A has further information)

MD/NP WELLNESS: Providing care to residents living in a PCH during a serious outbreak is an intense experience. Resident needs can increase quickly and unpredictably. Strains associated with this important work can be on top of the existing challenges the pandemic has presented. Seek out regional peer support resources

In addition, please consider accessing these resources from Doctors Manitoba and the CMA.

Physician and Family Support Program:

http://www.docsmbwellness.org/resources/docs-mb-services/

- o Accessible 24/7 at 1-844-436-2762 (register using DOCSMB as company ID).
  - For all Doctors Manitoba members and anyone living in their household.
- o Masters prepared counsellors are available for counselling in person, by telephone or video, and referrals to other services as needed.
- o https://www.cma.ca/physician-health-and-wellness/wellness-connection

Appendix A - Example of a Pandemic/Outbreak specific Standing Orders

Confirmed Medication Standing Orders

- There is an existing medication standing order set for PCH and TC residents who are confirmed to be positive. This is intended to support clinical judgement.
- The vast majority of residents will not require antibiotics for bacterial co-infection.
- VTE prophylaxis should be considered for residents with any decrease in ambulation. If VTE prophylaxis is not in keeping with goals of care the same should be indicated on the order form.

Supplemental O2

- O2 therapy is not on the Standing Orders. Instead, it is on the PCH Medication Standing Orders stating oxygen should be titrated to "O2 sat greater than 90% or their normal baseline".
- Oxygen is provided using concentrators. There are limits to the flow of oxygen that can be sustained at the PCH (5L/min). Oxygen by non-rebreather requires flows of 10 – 15 L/min, which cannot be provided using a concentrator.
- If oxygen at higher flow rates may provide clinical benefit and a transfer to acute care is in keeping with the goals of care this may need to be discussed with the resident and/or substitute decision maker and then the hospitalist or provincial ICU consultant.

IV and subcutaneous fluid for treatment of dehydration: IV therapy is not a standard part of PCH care in the absence of an outbreak.

- During an outbreak, staffing levels are adjusted based on the needs at the time. Redeployed staff may be able to establish IV and/or support the use of subcutaneous access.
- There are no pumps being used in PCH. Staff is educated to convert infusion rates into gravity fed drops/minute. The use of gravity fed intravenous fluid increases the risk of a large volume of fluid being accidentally administered if it is not closely supervised. Prescribers should inquire about the presence of staff competent in parenteral fluid and medication administration if considering orders and order fluid infusions as small volume boluses.
- More intensive IV or subcutaneous fluid can be provided in hospital. If there might be clinical benefit and transfer to acute care is in keeping with the goals of care, this would need to be discussed with the resident and/or the substitute decision maker and then the hospitalist or provincial ICU consultant.

Protected Code Blue PCH: There is an updated document that outlines the procedure for a Protected Code Blue in a PCH or TC unit.

Cohorting guideline: If multiple residents in a PCH are found to be positive you may be involved in decisions about room changes, otherwise known as cohorting. There is a detailed document that summarizes considerations relevant during these discussions.

IPC discontinuation of precautions: Physicians and nurse practitioners should not be asked to discontinue additional precautions, even when swabs come back negative for PCH residents. This is done in collaboration with Infection Prevention & Control.

Medication streamlining: Prescribers have already been asked to review medication lists throughout the pandemic. When safe for the individual residents, decreases in medication frequency to twice daily will significantly decrease nursing time and PPE use. This is the link to the province's advice about reviewing medications: Streamlining medication use during COVID-19

Death of a suspect/confirmed PCH Resident: PCH staff should report deaths by fax.

- "The Office of the Chief Medical Examiner (OCME) has jurisdiction over all deaths in an outbreak therefore the Practitioner of Record **DOES NOT need to sign the death certificate**. Please send the original death certificate to the OCME by mail for completion by the Medical Examiner."
- "All deaths from a respiratory or febrile illness must have a nasopharyngeal swab taken. **If this has not been completed insure a post-mortem Nasopharyngeal swab is taken.**

Education: There are a total of 8 locally produced presentations, that have been archived in a number of formats, specific to practicing in the PCH setting during the COVID-19 pandemic. The most recent is an update on medical care of PCH residents with COVID-19 https://www.cpd-umanitoba.com/covid-19-resources/ (on the bottom right of page).

- Seven of these are accredited to be reviewed in your own time by registering through the U of M CPD: https://www.cpd-umanitoba.com/online-learning/. PDFs for the 7 presentations are available by going to this same link. You can view 7 of the presentations on YouTube.
  - Clinical Frailty Scale
  - Goals of Care
  - Symptom Management
  - Chronic care of residents residing in PCHs
  - Delirium in the PCH during COVID
  - Mental health and BPSD
  - What to expect during COVID outbreak in PCH

Physician Wellness: Providing care to residents living in a PCH during an outbreak is an intense experience. Resident needs can increase quickly and unpredictably. Strains associated with this important work can be on top of the existing challenges the pandemic has presented. There are regional and/or provincial peer support resources. Contact your LTC/PCH Site Medical Lead or LATC/PCH Regional Medical Lead for further information. In addition, please consider accessing these resources from Doctors Manitoba and the CMA.

- Physician and Family Support Program:
  http://www.docsmbwellness.org/resources/docs-mb-services/
    - Accessible 24/7 at 1-844-436-2762 (register using DOCSMB as company ID). For all Doctors Manitoba members and anyone living in their household.
    - Masters prepared counsellors are available for counselling in person, by telephone or video, and referrals to other services as needed.
    - https://www.cma.ca/physician-health-and-wellness/wellness-connection

Personal Care Home/Transitional Care Centre Outbreak Facility Plan

Insert PCH Site

Purpose

The PCH will populate the facility plan template to ensure site readiness in the event of an outbreak. The outbreak plan will be used in conjunction with existing SDO policies and other SDO outbreak plans e.g. Respiratory outbreak.

This facility plan outlines minimum expectations and considerations in the event of an outbreak in PCH/TCC. Facilities are expected to populate the plan and develop task sheets to assign actions for all clinical and non-clinical staff. The completion of a site-specific plan will identify strengths of each site to meet challenges ahead and weaknesses that can be reviewed and addressed to enhance preparedness. Planning and preparedness will support resident care and prepare staff to maintain a safe, healthy and caring environment in challenging circumstances.

Outbreaks are continually changing and evolving therefore protocols, policies and resources are subject to change in response to this and will be communicated to site leadership.

The Pandemic plan will be reviewed annually and changes will be made based on written input from multiple stakeholders within the province. These stakeholders include but or not limited to SDO PCH leadership, First Nations Representatives, PCH operators, IPC, Communications, LTCAM and others as required.

Note The attached plan has been populated with key actions to consider in planning. The action items are to assist the site in populating their plan. Actions may be added, changed, altered based on the facility structure and existing directions provided by the SDO leadership.

Documents to include in Outbreak Response Binders/Kit

a) Testing and collection,
b) Reporting tools (line lists)
c) PPE
d) Staff resources (Mental Health)
e) Nutrition and Hydration
f) Resident screening tools e.g. Stop and Watch Early Warning Tool
g) Provincial Outbreak posters
h) Provincial Posters Cough Etiquette and Hand Hygiene
i) Visitor signage
j) PPE and Hand Hygiene audits
k) Facility floorplan/layout

PCH Profile

PCH/TCC name			# of beds	
PCH/TCC physical address			# of units and beds/unit	
Phone number			# of double occupancy rooms	
Fax number			# rooms sharing a bathroom	
Juxtaposed	*(Yes/No)*	To what facility/building:		

Key List Locations

Facility	
Title	**Location**
Facility contact list *Site Lead, Administrative Assistant, Client Services Manager, Clinical Resource Nurse, Unit Clerk, Chief of Staff, Medical Clinic (Physicians/Nurse Practitioners), site-level Infection Control Practitioner/Staff development, Environmental Services Manager (& leads for housekeeping/laundry, maintenance), Food Services Manager, LTC pharmacy, Materials Management, community public health*	
Service Delivery Organization (SDO) contact list *Medical Office of Health (MOH), MOH on-call (after hours and weekends), Regional IP&C (weekday & weekends from 8:00-16:00), Senior Leader/Administrator on-call (after hours), pharmacy contact (after hours), media intake line*	
Staff contact list	
Staff schedules (nursing, housekeeping, dietary, laundry, other)	
Resident family contact list	
Current Resident List	
Designated family caregiver contact list during outbreak	

First Contact/ Family designate	
Legal decision maker (Proxy/SDM/Committee)	
Power of Attorney	

Appropriate Levels of Supplies

Consider: PPE, alcohol-based hand rub, soap and paper towels, testing supplies, cleaning and disinfectant supplies, oxygen cylinders, concentrators, isolation carts, etc. Each site should have ONE CONCENTRATOR per resident prescribed 02, and 1-3 spare concentrators depending on size of facility.

Type of Supply	Location(s)	Minimum Quantity

*Required supplies will be determined by the organism contributing to the outbreak.

Infection Prevention and Control

Existing Checklists for completion
COVID-19 Individual Case Management Checklist found here: https://sharedhealthmb.ca/files/covid-19-pch-individual-case-management-checklist.xlsx
COVID-19 Outbreak Checklist found here: https://sharedhealthmb.ca/files/covid-19-pch-outbreak-checklist.xlsx

The IP&C checklists have been removed from the Provincial LTC Pandemic Plan as they are updated on a more frequent basis dependant upon the type of infection/outbreak.

SECTION 1: OUTBREAK TASK SHEETS

Senior Administrative Checklist

	Outbreak Measures
Date/Time Initial	
	CEO to notify Deputy Minister of Outbreak
	Coordinate a communication plan
	Establish outbreak team with appropriate members and assigning functions
	Advocate for appropriate human logistical and financial resource requirements
	Provide frequent leadership presence, communication, direction and support to staff
	Ensure debriefing and evaluation of outbreak occurs
	Designate Communication Lead and back up person responsible for communication to families during an outbreak. Communication Lead (see task sheet) Backup/Alternate

Nursing Outbreak Task Sheet

Prior to outbreak being declared, ensure case(s) have been reviewed with ICP/designate to **confirm** that outbreak case definition met.		
INITIAL OUTBREAK NOTIFICATION		
Date/Time	Initial	
		Nurse in charge notifies Manager
		Site specific process to take place to notify residents and family/visitors of outbreak.
		Outbreak signage to be posted upon entry to unit/facility
OUTBREAK MEASURES		

		Infection Prevention and Control Management:
		 • Refer to Respiratory Illness and Gastrointestinal Illness Outbreak Management: which includes the following recommendations:
		     o Additional Precautions (Implementation and Discontinuation)
		     o Testing and Specimen Collection
		     o Antiviral Prophylaxis (if recommended)
		     o Occupational Health
		     o Cohorting Staff
		     o Environmental and Equipment Cleaning/Disinfection
		     o Laundry/Dishes/Garbage
		     o Nutrition Services
		     o Admission Recommendations
		     o Transfers
		     o Visitation
		     o Activities
		 • Contact Tracing for residents and/or staff – recommendations will be provided by IP&C dependent of type of outbreak (also considering causative organism)

		Clinical Management: • Review upcoming resident appointments and cancel any non-urgent appointments • Review physician binder and suspend rounds for any non-urgent issues (in collaboration with physician and management) • Care plan/quarterly review-attendance at these will be dependent on availability of staff and workload • Facilitate frequent check-ins and additional fluid intake and monitor for any signs of dehydration o Consider implementing 24-hour fluid balance record for

		resident
		• Exercise/mobilization
		• Resident assessment:
		  ○ Monitor known contacts of isolated residents (i.e. Tablemates).
		    ▪ If applicable depending on organism use Screening assessment tool to document monitoring

		Communication: • Provide regular updates to residents on unit regarding status of outbreak • Provide regular updates to family regarding status of outbreak • Inform management of concerns during outbreak • Provide updates to Social Worker/designate and administrative staff so that they can help in facilitating family communication • Provide updates to communication lead/designate so that they can help in facilitating family communication. Ideally, clinical staff should be contacting infected resident's families proactively and regularly. If this is not possible, work with management /communication lead to bring in supports to assist with this communication
		If Cohort area planned: • In consultation with manager, identify where equipment will be stored
		Any media requests to be directed to _____
	ONCE OUTBREAK TERMINATED	
		Site specific process to ensure residents and family are aware
		Outbreak signage removed
		Continued heightened surveillance
		Complete outbreak evaluation tool and submit to manager

Health Care Aide Outbreak Task Sheet

OUTBREAK MEASURES		
Date/Time	Initial	
		Notify nursing staff of residents who have developed symptoms
		Infection Prevention and Control Management: • Refer to Respiratory Illness and Gastrointestinal Illness Outbreak Management
		Inform management of concerns during outbreak
		Any media requests to be directed to _____
ONCE OUTBREAK TERMINATED		
		Site specific process to ensure residents and family are aware
		Outbreak signage removed
		Continued heightened surveillance
		Complete outbreak evaluation tool and submit to manager

Management Outbreak Task Sheet

Prior to outbreak being declared, ensure case(s) have been reviewed with ICP/designate to **confirm** that outbreak case definition met.
UPON INITIAL OUTBREAK NOTIFICATION
Date/Time	Initial	
		Manager receives notification of outbreak declaration from ICP/designate and/or nurse in charge. Manager then notifies: • Director (SDO Lead) • Physician lead of site • Manager leads of site (i.e. environmental services, nutritional services, maintenance, activities, lab/diagnostics, pharmacy, materials management etc.) • Staff at site (i.e. site-specific process re: call out to all staff at site)

		Schedule staff huddle to review initial outbreak measures:
		• Outbreak signage posted upon entry to unit/facility
		• Implementation of Additional Precautions
		• Specimen collection and identification of outbreak code on requisition
		• Screening residents for symptoms
		• Communication plan to residents, family and visitors
		• Hand Hygiene
		   o Review 4 moments of hand hygiene for staff
		   o Remind staff to assist residents with hand hygiene before meals and after using bathroom if unable to manage independently
		• Review plan for admissions/transfers
		• Review visitation plan
		• Review plan for activities on unit/facility
		• Reinforce importance of equipment cleaning
		• Where to direct media calls

		Resident care communication: – Take a photo of each resident, print copies for identification purposes. Replace photo on MAR, Care Plan, and in all other locations where resident photo is required. – Review and update care plans – Ensure communication boards are up to date. Include 1 photo of the residents on the outbreak door poster and one photo in a visible location in the resident room.
		Provide orientation for: – HCA and volunteers – Nursing staff

		− Allied health roles − Additional housekeeping support − Security staff All new staff to facility
		ONGOING OUTBREAK MEASURES
		Contact Tracing for residents and/or staff – recommendations will be provided by IP&C dependent of type of outbreak (also considering causative organism)
		Collaborate with IP&C/designate through the course of the outbreak
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		Communication: • Delegate the release of communication scripts for families and staff to communication lead/delegate via email/phone calls – Communication scripts. • Encourage family that want updates to connect with communication lead/designate • Ensure that clinical staff are contacting infected residents families proactively and regularly. If this is not possible, work with communication lead to bring in supports to assist with this communication. • If staff case, delegate communication lead to send off positive staff member communication script email to all staff and families.
		Staffing: • Consider increasing staff complement to care for acutely ill residents • Cohort staff to specific units or patient assignments, if possible o If unable to dedicate staff workflow should move from non-infected to infected residents ensuring adherence to routine practices • Restrict staff movement in the daily assignments from outbreak affected areas to non-affected areas, if possible • Consider 1:1 supervision for residents who are unable to comply with IP&C measures • Monitor staffing and redirect non-clinical staff to support clinical tasks as needed • Assess need for security
		Supplies: • Ensure process in place to monitor need for supplies. i.e. oxygen cylinders/concentrators
		Occupational Health:

		• Liaise with Occupational Health/designate when there are symptomatic staff • Discuss with OMT re: implementation of active staff screening.
		PPE: • Assist with monitoring of PPE supply use/burn rate • Assess HCW fit testing (as required)
		Preparation for cohorting (if required): • In consultation with IP&C/designate, review the need to set up cohort area • Housekeeping and maintenance staff to be coordinated to assist with moving patient/furniture etc. • All patient belongings labelled before moving • Nurse/ Health Care Aide/Housekeeper are to be dedicated specifically to cohort area • All other staff are to avoid walking thru area as much as possible. • Two-way radios provided to staff in cohort area to communicate with other nursing staff. • Table to be set up to allow for charting/documentation. • All patient meals provided in their rooms in cohort area. • Work with scheduling to ensure that nursing staff, housekeeping, HCA's are assigned to cohort area
		Audits: • Monitor staff compliance with PPE use and hand hygiene • Monitor staff screening – give consideration for reimplementation of in-person staff screener
		Mental Health Resources for staff: • Delegate administration staff to send out mental health resources to staff via email
		Huddles: • Have regularly scheduled staff huddles throughout outbreak to reinforce outbreak measures (i.e. Additional Precautions, Hand Hygiene, Visitation principles)
		Visitation/External Service Providers

		• Review with SDO leadership/IP&C need to suspend visitation. If visitation cancelled, have communication lead/administrative staff assist with notifying families. • Review suspension of external care providers • Review physician visits to site • Plan for acquisition of additional hand-held devices for virtual family and physician check ins
		Complete **Incident Command (RIC) Reporting** daily and submit to Regional Lead Community & Continuing Care, PCH-Directors, IP&C providers and Human Resources
	ONCE OUTBREAK TERMINATED	
		Site specific process to ensure residents and family are aware
		Outbreak signage removed
		Ensure heightened surveillance continues
		Arrange for outbreak debriefing

Dietary Outbreak Task Sheet

ONGOING OUTBREAK MEASURES		
Date/Time	Initial	
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		Prepare separate meal cart, as those residents on Additional Precautions will be served in their rooms.
		If dedicated co-horted area implemented at site: • Meals delivered to cohort area via cart by dietary staff- will be picked up at cohort area and distributed by nursing staff. Trays will be distributed in cohort area by nursing staff, collected, and placed back on the cart. • Ensure additional dietary supplies i.e. water, and snacks are provided to cohort area as well
		Ensure that tables are set just prior to meal times to decrease risk of contamination
		Work with management to stagger meal times as needed
		Implement modified/simplified menu as needed including premade meals
		Be prepared to assist residents in the dining room with their meals as well other tasks such as preparing toast, cutting up items etc.
		Consider suspending staff meal service in consultation with management if workload is exceeding staff capacity.
		Be prepared to take on additional care tasks as needed/directed by management (i.e. staff screening)

Maintenance Outbreak Task Sheet

ONGOING OUTBREAK MEASURES		
Date/Time	Initial	
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		If cohorting implemented: • Assist staff in setting up cohort area for ill residents including moving furniture etc. as needed • Assist with posting appropriate signage in cohort area and to limit staff movement • Plan for additional long-term external storage e.g. portable lockable containers for personal effects of residents
		Assist with procurement/movement of supplies in the building i.e. Portable 02 tanks, monitoring 02 use at the hospital etc.
		Plan for increased waste management i.e. increase number of waste receptacles, disposal of waste
		Be prepared to take on additional care tasks as needed/directed by management (i.e. staff screening)

Activities/Recreation Outbreak Task Sheet

Date/Time	Initial	ONGOING OUTBREAK MEASURES
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		If direction from management is received to suspend all visitation: • Ensure that visitation cancellations are communicated to families • Assist residents in utilizing virtual means to communicate with family (i.e. iPad and telephone)
		Isolation Care Plans • Ensure that isolation care plans are up to date • Prepare items for isolation care plans and place in resident rooms that are on Additional Precautions
		Assist with resident socialization, virtual and 1:1 visits
		Assist in other care tasks as directed by manager

Primary Care Provider/Physician/Nurse Practitioner Outbreak Task Sheet

ONGOING OUTBREAK MEASURES		
Date/Time	Initial	
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		Orders laboratory testing as indicated and as directed by the MOH/designate during an outbreak
		Consults with MOH/IP&C physician as required
		Orders antiviral treatment as required
		Orders antiviral prophylaxis using pre-calculated antiviral dosages
		Depending on causative organism and extent of outbreak, Physician compliment to determine physician/Nurse Practitioner (NP) who will make in-person daily visits to PCH. • Other physicians/NP to utilize virtual means i.e. phone conference, face time to be on call for support
		Review daily line lists and complete medication reviews for acutely ill residents
		Ensure awareness of all resident's Advanced Care Plan/Goals of care and expressed wishes
		Assist nursing staff in communicating resident's health status
		Discuss with Outbreak Management Team (OMT) regarding continuation of Scheduled Medication Reviews during outbreak

Social Worker/Communication Lead Outbreak Task Sheet

(note: that in many cases the social worker may be the communication lead or designate. Please see communication lead task sheet)

ONGOING OUTBREAK MEASURES		
Date/Time	Initial	
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		Participate in nursing shift report and staff huddles to assist in communication with families.
		General family inquiries will be directed first to Social Worker/designate and SW/designate will seek out additional individuals to communicate with families as needed
		Be prepared to provide emotional/end of life support to families as needed
		Assist in ongoing care planning, and annual reviews virtually as able.
		Assist in the facilitation of virtual visits with families/residents
		Assist in the facilitation of 1:1 visits and virtual visits for residents in isolation etc.

Administration Outbreak Task Sheet

Administrative Assistant, Finance Clerk, Scheduler

ONGOING OUTBREAK MEASURES		
Date/Time	Initial	
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		Assist with distribution of communication scripts to resident families as directed by management/communication lead
		Assist with distributing Mental Health Resources information to staff via email/phone calls as directed by management/communication lead
		Review all upcoming scheduled meetings and cancel/defer meetings
		Assist with communication of changes to visitation guidelines as directed by management/communication lead
		Assist with Visitor Screening as directed by management
		Assist with posting signage to identify outbreak, cohort area, and limiting staff movement
		Assist with cleaning/disinfecting high touch items in other areas as directed by management
		Complete daily inventory of PPE stock and ensure ordering as required
		Ensure that PPE order sheet is up to date and administration office/staff are aware of where it is located.
		Communicate any anticipated shortages of supplies with management ASAP
		Be prepared to take on additional care tasks as needed/directed by management (i.e. staff screening)
		Finance • Ensure that any additional expenses are coded as directed by management
		Scheduler: • Work with management to ensure communication of any potential staffing vacancies ASAP, priorities for replacement, and expected staffing gaps. • Be prepared to assist in distribution of communication scripts to staff members.

Environmental Services/Housekeeping Outbreak Task Sheet

ONGOING OUTBREAK MEASURES		
Date/Time	**Initial**	
		Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		If cohorted area in place: • Staff to be specifically dedicated to cohort area ○ If unable to dedicate staff workflow should move from non-infected to infected residents ensuring adherence to routine practices. • Environmental Services to be prepared to assist with moving residents as needed to cohort area.
		Clean and disinfect all high touch surfaces in outbreak affected area(s) at least twice a day. This includes: • High-touch surfaces (e.g. handrails, tap handles, faucets, door handles, soap dispensers, furniture, phones, computer keyboards etc.) • Care areas and common areas such as dining/activity areas and lounges
		In consultation with management suspend tasks that can be delayed/ suspended ie project cleaning, annual cleaning etc.
		Priority for laundry would be isolation gowns, cleaning supplies, and patient linen • Residents have a 7-day supply of clothing- can defer personal laundry if needed to accommodate priority wash items
		Continue to use routine practices for dietary, laundry, and waste management- no special precautions are required.
		Be prepared to take on additional care tasks as needed/directed by management

Infection Prevention and Control (Site and/or Regional) Outbreak Task Sheet

IDENTIFICATION AND CONFIRMATION OF OUTBREAK		
Date/Time	Initial	
		Determine if Outbreak Present • Review data being reported to determine if there is a potential outbreak • If clinical findings indicate the criteria meet the outbreak definition, review information to confirm outbreak status as per SDO process
ONCE OUTBREAK DECLARED		

		• Establish a working outbreak case definition
		• Ensure an outbreak code is obtained from Cadham Provincial Laboratory (CPL) as per established SDO processes.
		  o Cadham Lab #204- 945-7473 or #204-945-7311
		• Ensure appropriate IP&C measures are implemented in a timely manner
		• Notify, in collaboration with Manager, all appropriate stakeholders and departments there is an outbreak; include all pertinent information
		• Determine the number of specimens to be performed (usually up to a maximum of 6; may be increased depending on causative organism).
		• Refer to IP&C recommendations in Respiratory Illness and Gastrointestinal Illness Outbreak Management
		• Site and Regional IP&C to communicate daily during outbreak.
		  o If no site IP&C, regional ICP to communicate daily with site lead to assess outbreak.
		• Direct outbreak control strategies appropriate to the type and scope of outbreak
		• Provides guidance on contact tracing as required depending on type of outbreak
		• Obtain report on the clinical status and identify new cases from unit on a daily basis
		• Notify MHSC of the outbreak by completing an outbreak summary using the Canadian Network for Public Health Intelligence (CNPHI) reporting system
		• Ensure increased auditing, as required, for hand hygiene, PPE use and equipment cleaning and disinfection in collaboration with site leadership
		• Ensure outbreak control strategies are maintained until the outbreak is declared over following outlined SDO processes
		• Escalates IP&C risk issues for awareness and collaborative

		problem solving
		• Report as required by legislation and regional policies. Report deaths per Public Health Act, Reporting of Diseases & Conditions Regulation
		• Site Visit(s) During Outbreak
		o If no site IP&C present, regional ICP to attend site in person to review outbreak measures as soon as possible with a goal to attend within the first 4 days of outbreak being declared.
		o If site IP&C present, communication daily with regional ICP to take place. If questions/concerns or request from site, regional ICP to make site visit.
		o Further site visits assessed on an as needed basis
		• Redeployment of regional ICP to outbreak site may be needed:
		o If Site IP&C is redeployed or absent for extended period
		o If outbreak not controlled
		o If deemed appropriate by regional IP&C program
		o On as needed basis in consultation with OMT
**OUTBREAK TERMINATION**
		• Declare outbreak over in collaboration with MOH/designate as per SDO process
		• Notify site/manager of outbreak termination
		• Complete outbreak evaluation tool and share with manager
		• Receive collated site outbreak evaluation information from manager
		• Complete and finalize CNPHI Report
		• Complete and submit Outbreak Summary Report Template to OMT

Pharmacy Task Sheet

ONCE OUTBREAK DECLARED		
Date/Time	Initial	
		Notify the PCH pharmacist about the outbreak and include: • Confirmed or suspected organism • Location of cases (e.g. unit, building, etc.) Number of resident cases and symptoms
		Medication Orders
		Confirm applicable medications have been initiated for resident cases i.e.. For Influenza, oseltamivir treatment
		Follow-up with the prescriber before the end of the medication treatment course for applicable medications
		As residents are recovering, discuss discontinuation of medications specific to the infection
		Wardstock/Stat Box
		Discuss with the pharmacist medications that may require temporary addition to the PCH stat box during the outbreak with approval from the PCH Pharmacy Manager E.g., For COVID-19, dexamethasone 2 mg x 10 tabs; dexamethasone 4 mg x 10 tabs; dalteparin 5,000 units pre-filled syringes x 10; site-specific: dexamethasone 4 mg/mL (5 mL vials) x 3
		Pharmacist provides a wardstock/stat box reorder form specific to medications expected to have increased use during the outbreak
		Identify a dedicated PCH individual to do DAILY monitoring of the medications expected to have increased use during the outbreak
		Medication Deliveries

		Reassess the frequency of medication deliveries and transportation system
		Reassess the location for medication deliveries
		Communication
		Establish a communication plan between the pharmacist and the PCH prioritizing a detailed review of preparations on Thursdays for the weekend
		Pharmacist participates in the PCH incident command meetings as required/available
		Establish a process where the pharmacist is notified about new resident cases
		If resident cohorting is occurring, review with nursing a plan to update pharmacy on changes to room numbers
		Medication Streamlining
		Pharmacist connects with the prescriber to review opportunities for streamlining medications with a focus on decreasing medication pass times
		Pharmacy Onsite PCH Visits
		Pharmacist to provide a list of scheduled onsite PCH visits
		Quarterly medication reviews (QMRs) • QMRs should proceed as scheduled • Pharmacist and PCH to discuss if QMRs can be conducted onsite or completed virtually with consideration given to: o Where is the outbreak? o How many cases? o Where are the QMRs conducted? A location outside the resident units is recommended o Can virtual QMRs be supported? Is nursing available to participate? QMRs can proceed with only prescriber and pharmacist if nursing resources are short
		Medication room audits

		• Pharmacist and PCH to discuss scheduled medication room audits during the outbreak with consideration given to:
		
		    o Should the medication room audits be postponed until the PCH outbreak is resolved?
		
		    o Do all the medication room audits need to be postponed or just the affected unit(s)?
		
		    o When can medication room audits be rescheduled?
		
		    o Can nursing perform a medication room audit in the interim to remove any expired products?
		
		Implications for Manitoba Health PCH Standards

		Pharmacy & Therapeutics (P&T)/Medical Advisory Council (MAC) Meetings
		
		• PCH to consider scheduled P&T/MAC meetings with consideration given to:
		
		    o Can the meeting proceed in a space outside the resident units?
		
		    o Should the meeting be postponed until the PCH outbreak is resolved?
		
		    o Can the meeting be held virtually (e.g. Zoom, Microsoft Teams)?
		
		Implications for Manitoba Health PCH Standards

		Pharmacy education in-services
		
		• PCH to consider pharmacy education in-services with consideration given to:
		
		    o Can the in-service proceed in a space outside the resident units?
		
		    o Should the in-service be postponed until the PCH outbreak is resolved?
		
		Can the in-service be held virtually (e.g. Zoom, Microsoft Teams)?

Communications Lead Task sheet

It is important to designate a communication lead and back up prior to an outbreak for families. In many cases, the communication lead may be the site operator or social worker

Date/Time	Initial	Once outbreak declared
		Identify a communication lead (social worker/other designate) to communicate with families (this may be more than one person/one person assigned to multiple residents)
		General family inquiries will be directed first to the communication lead and lead will seek out additional individuals to communicate with families as needed.
		Ideally, clinical staff should be contacting infected resident's/families proactively and regularly. If this is not possible, work with management/ nursing staff to help with this communication such as updates from nursing staff on individuals' well-being. Ensure participation in nursing shift report to assist in this communication with families.
		Determine the process for how the communication lead designate will proactively provide updates to families, including: • When & how often they will be contacted (i.e. once per week on Mondays between 3 to 5) • How they will be contacted (phone, email, etc.) • What information they will receive
		Determine the process for how family members can contact the communication lead/designate for updates: • When the designate is available (i.e. Tuesdays from 3-5 p.m.) • How they can be contacted (phone, email, etc.) • What information they can provide
		Identify an administrative staff member to provide regular updates on the facility, current public health orders, & any other site-wide information.

		Determine the process for providing site-wide updates: - When & how often they will be provided (i.e. once per week on Mondays at 5 p.m._ - How they will be provided (email, website, virtual town hall, etc.) - What information will be provided
		Develop key messages regarding communication with families.
		Provide communication scripts with key messages to administration staff to assist in handling calls from family members looking for updates.
		Update website with details of communications processes.
		Contact families to inform them of communications processes.

In recognition for the exemplary work completed by the Prairie Mountain Health Region we have attached two documents to better prepared Personal Care Homes for future pandemics, through lessons learned from COVID19.

Initial response to a COVID19 outbreak

PRAIRIE MOUNTAIN HEALTH
Personal Care Home (PCH) Initial Response to a COVID- 19 Outbreak

Abbreviations

- CTM: Care Team Manager
- NP: Nurse Practitioner
- EMT: Executive Management Team
- IP&C: Infection Prevention & Control
- MOH: Medical Officer of Health
- ILI: Influenza Like Illness
- PPE: Personal Protective Equipment
- DEPP: Disaster & Emergency Preparedness Program
- ERMS: Emergency Response Management System
- ACP: Advanced Care Plan

Personal Care Home (PCH) Initial Response to a COVID- 19 Outbreak

Notification of Positive Result

☐ 1. Nurse in charge notifies CTM/CTM on call
☐ 2. Incident command is setup – Terms of Reference Site ICS (PMH3220) & Minute/Action Plan Template (PMH3221)
☐ 3. IF Positive case is a Resident, Nurse in Charge contacts Physician/NP
☐ 4. CTM/CTM on call notifies appropriate Director positive result is staff or resident
☐ 5. Director confirms notification of EMT and site Medical Director _____ *
☐ 6. Nurse in charge refers to LTC Resident Visitation Principles to determine visitation allowances and takes necessary steps. *
☐ 7. Nurse in charge instructs staff to follow PMH outbreak policy (PPG-00011)
☐ 8. Nurse in charge ensures IP&C/MOH is aware of resident test results
☐ 9. Director notifies all management to report to site- including support services.
☐ 10. Provide a contact name from staffing to assist Occupational Health/IP&C/Public Health with contact tracing
☐ 11. All PCH admissions placed on hold.

Isolation

☐ 1. All residents to be assessed for ILI symptoms, including temperature checks*
☐ 2. Symptomatic residents are placed on Contact/Droplet precautions
☐ 3. Symptomatic residents are swabbed as per direction from IP&C in consultation with MOH*
☐ 4. Isolation signage is posted as per regional process
☐ 5. Re-screen all staff on shift including temperature checks
☐ 6. Ensure adequate supply of PPE; place order if needed *
☐ 7. Consider review of PPE Donning and Doffing *

Communication

☐ 1. Communication to families and all site staff organized by Incident Command *
   ☐ Retrieve scripts off intranet
   ☐ Modify/prepare each script
   ☐ Assign staff to email communication to families
   ☐ Email Mgr Disaster Emergency Preparedness or DEPP & copy VP to initiate ERMS message to all staff
   ☐ Send follow-up email communications to all staff in facility
   ☐ Email/mail communication letter to families
   ☐ Phone families of symptomatic resident(s)
   ☐ Phone families of non-symptomatic residents
☐ 2. Ensure all staff are aware to send all media requests to PMH Communications*
☐ 3. Develop plan for regular updates/communication to families
☐ 4. Management to consider greeting staff at all shift changes for first 3 days
☐ 5. Management to send out regular updates to all staff
☐ 6. For any deaths, notify funeral home of outbreak and Covid status. *

Containment

☐ 1. If direction from MOH is to cohort symptomatic residents, implement site specific cohorting plan*, considering Cohorting Guidelines (PMH3174)
   ☐ Notify Environmental Services re: need to terminal clean of rooms prior to move
☐ 2. Management to consider dedicating staff to care for symptomatic residents where feasible
☐ 3. Explore further opportunities for social/physical distancing of asymptomatic residents in dining /modified recreational activities

Treatment

☐ 1. Ensure adequate supply of oxygen cylinders and concentrators *
☐ 2. Review Advanced Care Plan of symptomatic residents with families *
   ☐ Consider creating a list of residents with their ACP level
   ☐ Consider getting assistance from Palliative Care nurse/Medical Director
☐ 3. Discussion with pharmacy to determine any additional medication needs *
☐ 4. Determine and/or assess vitals on all residents to establish baseline.

*Refer to Associated document

NOTE: One positive staff or resident in the site constitutes a COVID outbreak

Original Effective Date: 2020-May-20
Revised Effective Date: 2020-Oct-07

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PCH COVID- 19 Outbreak Checklist Considerations

Supplies

Review quantities on-hand and determine quantities required.

Include all pertinent departments

☐ 1. Resident Care Supplies: Mouth/Lip Care – toothetes, Biotene/Moistir spray/water, Eye Care – eyes drops, lid care wipes; Disposable wipes for Peri-Care; Disposable bathing products (e.g. Hygie, Tena), foley catheters and catheterization equipment, pressure relief surfaces.
☐ 2. Linens: Peri-cloths; soaker pads; washcloths (hand hygiene & bathing); flannels; patient gowns; Reusable isolation gowns; Laundry Carts; garbage bins
☐ 3. Dedicated equipment for Covid positive: blood pressure machine; thermometer; transfer equipment; glucometers; SPO2 monitors; stethoscopes.
☐ 4. Medications: Review needs with pharmacy
☐ 4. Consider Medication Storage on the Covid +/Cohorting ward.
☐ 5. Cohorting equipment: commodes, washbasins, urinals,
☐ 6. Nutrition Services/Nourishment Supplies: Meal Cart; Trays; Thermal Covers; Carafes/Mugs; Over bed tables; Fridge (additional? Re-dedicated?); Single Service Beverages/foods; Dishes; snacks/foods for the unit/area
☐ 7. Cleaning Supplies: PMH approved disinfectants.
☐ 8. PPE: Routine ordering, inclusive of N95 masks.
☐ 9. Covid Testing: ongoing supply of Covid-19 test kits/requisitions
☐ 10. Documentation: wipeable clipboards

PPE

☐ 1. Designate a separate room/location for donning PPE & a separate room/location for doffing PPE (if applicable in a cohorting situation).
☐ 2. Have another staff monitor your donning/doffing to ensure correct application and sequence. Use Enhanced Droplet Contact Audit Tool*.
☐ 3. During Shift, have another staff buddy monitor your PPE for soiling, wet/damp masks, ties, space between masks, goggles

Resident Care Tasks

☐ 1. Hand Hygiene for all residents before meals
☐ 2. Bathe residents using the 5 washcloth system: basin of water and 5 cloths. 1-face/neck/chest; 1-arms/abdomen; 1-perineum front and legs; 1-back; 1-perineum back side
☐ 3. Bundling resident's care to minimize entry into the room:
　o Performing assessments, vitals, med pass, meal delivery, glucometry checks, turning and positioning, bathing at same visit in the room
　o Meal trays may stay in the room until the next meal delivery
☐ 4. Increased cleaning of equipment:
　o hand hygiene & new gloves donned prior to cleaning, and these gloves doffed/hands hygiene when cleaning completed.
　o Allow equipment to dry prior to next use- timelines as per cleaning agent used (Prevention Wipes – 3 minutes; Oxivir Plus – 5 minutes)
☐ 5. Meal Delivery into the unit/resident's room to minimize exposure:
　o brought to door/unit on 1 cart; transferred to the cart in the room/unit & delivered by donned staff member.
　o deliver/remove trays to/from rooms while bundling care
☐ 6. Administering Medications:
　o Nurse performs 5 rights of medication administration outside the room with the MAR, then takes medications only into the room;
　o Buddy nurse stands outside the door with the MAR, to assist with identification of resident (familiarity/photo)
　o After nurse administers medications (following appropriate PPE guidelines)
　o Signs MAR outside of room
☐ 7. Identify and report any subtle changes in a resident to Nursing, using Stop and Watch tool.

Documentation

☐ 1. Charts do not enter Covid + room and do not leave a Covid + area
☐ 2. Bedside flowsheets/clipboards are not brought back to desk for documentation.
☐ 3. Potential for buddy system and/or other options to aid in documentation/note taking.

NOTE: One positive staff or resident in the PMH site constitutes a COVID outbreak

PRAIRIE MOUNTAIN HEALTH

PCH COVID- 19 Outbreak Checklist Considerations

Treatment

Provincial Guidance for Palliative Care Communication

☐ 1. Consider increasing professional staff complement to care for acutely ill residents. (Nurse to resident ratio 1:6)
☐ 2. Mouth Care / Eye Care Orders
☐ 3. PMHMSO.195 Confirmed Covid-19 Medication Standing Orders
☐ 4. Review use of CPAP/BI-PAP & availability of N95 masks
☐ 5. Turn off fans.
☐ 6. Frequency of covid specific assessments determined by physician's order/Standing orders, clinical judgement, resident status and goals of care.
☐ 7. Frequent monitoring of respiratory status (including SpO2), dependent on resident status.
   o maintain SpO2 greater than 94% unless otherwise ordered. If required to titrate up oxygen to maintain SpO2, notify primary physician.
   o consider: respiratory effort, work of breathing, activity tolerance, cough, sputum production, chest sounds
☐ 8. Implement 24- Hour Fluid- Balance Record (PMH875, PPG-00634)
☐ 9. Review & implement Nutrition and Hydration Policy Strategies (PPG-01977)
☐ 10. Continue with other necessary assessments and treatments. (e.g. wound care, restraints).
☐ 11. Consider Guidance for supporting Clients who Wander and Require Physical Isolation*.

Environmental Services

☐ 1. Clean & disinfect high touch surfaces in resident rooms & common areas a minimum of twice daily and when soiled. (IP&C PCH)
☐ 2. Clean & disinfect all low touch surfaces at least once daily and when soiled. (IP&C PCH)
☐ 3. Terminal cleaning for cohorting, following a death, or lifting of restrictions
☐ 4. Increased Laundry services at the site as needed to manage increased linen demand

Communication

☐ 1. Site Incident Command Team – Terms of Reference (PMH3220) & Minute/Action Template (PMH3221)
☐ 2. Resident Care Communication:
   o Take a photo of each resident, print copies for Resident Identification purposes – replace photo on MAR, Care Plan, and Pouch Porter Boxes and anywhere else there is a photo
   o Care Plans are up-to-date
   o Communication boards are up-to-date
   o Implement Outbreak Door Poster (PMH3194), including 1 photo (clarify resident room door)
   o Put the another photo up in the resident room in a visible location
☐ 3. Communication with practitioners – determine mode/frequency
☐ 4. Communication with families - determine mode & frequency for each unit/color zone.
☐ 5. Ongoing Communication/debriefing with staff – determine mode/frequency
   o ensure updates occur at each change of shift
   o ensure daily communication to staff not at work

Education

☐ 1. Determine education requirements for any redeployed staff, volunteers, or family caregivers. Available resources include: Orientation for HCA & Volunteers; Orientation for Nursing Staff; Allied Health Roles. * Consider tasks and time available.

Considerations

☐ 1. Daily visits from: MHRN, Spiritual Care, Physician/NP
☐ 2. Visible leadership in the facility days/evenings/nights/weekends
☐ 3. Review social distancing in dining rooms: are there further steps that should be taken?
☐ 4. Location to store supplies in a red zone
☐ 5. Air Temperature - Cooling considerations for sites depending on time of year
☐ 6. Suspend all recreation activities
☐ 7. Implement Resident Visitation Principles based on Level.
☐ 8. Ways to keep COVID positive residents connected with family
☐ 9. Keep a supply of cardboard boxes readily available for packing resident belongings.
☐ 10. Consult Palliative Care as necessary (regular and off hours).
☐ 11. Review Physical Distancing Guidelines & complete Covid-19 Physical Distancing Audit Tool

NOTE: One positive staff or resident in the PMH site constitutes a COVID outbreak
Original Effective Date: 2020-Aug-04
Revised Effective Date: 2020-Sep-08

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