

A Guide to Influenza Pandemic Preparedness and Response in Long-Term Care Homes

Emergency Management Unit
Ministry of Health and Long-Term Care

December 2005

Table of Contents

Preface	4
1.1 How to Use the Guide	4
Acknowledgements	6
1. Introduction	7
1.1 About Influenza	7
1.2 Seasonal Influenza vs Influenza Pandemic	7
1.3 Planning Assumptions	8
1.4 Ethical Considerations	9
1.5 Protecting Health Care Workers	10
1.6 WHO Pandemic Periods and Phases	11
1.7 Emergency Management Roles and Responsibilities	12
2. Preparedness	15
2.1 Planning	15
2.1.1 Coordinate Planning with Other Health Organizations	15
2.1.2 Review and Update Emergency Plans.....	16
2.1.3 Establish an Influenza Pandemic Outbreak Management Team and Communicate Chain of Command to Staff	16
2.1.4 Assess Residents' Care Needs	16
2.1.5 Identify Essential Services/Services that Could Be Curtailed.....	17
2.1.6 Identify Priority Groups for Access for Antivirals and Vaccine	17
2.1.7 Storage and Tracking Systems for Antivirals.....	20
2.1.8 Identify Required Supplies/Alternative Supply Chains	20
2.1.9 Identify/Train Human Resources.....	20
2.1.9 Review and Update Communication Plans	21
2.1.10 Review Security and Physical Plant	21
2.1.11 Review and Update Policies	21
2.2 Immunization Policy	22
2.2.1 Residents.....	23
2.2.2 Staff and Volunteers.....	23
2.2.3 Visitors.....	24
2.2.4 Immunization Status Reports	24
2.3 Surveillance	24
2.3.1 Goal of Surveillance in Long-Term Care	24
2.3.2 Responsibility for Surveillance.....	24
2.3.3 Target Groups for Surveillance.....	24
2.3.4 Role of Public Health	26
2.4 Education	27
2.4.1 Education Plans	27

2.4.2 Education Programs	27
3. Pandemic Response	29
Response Level by Pandemic Phase	29
No Pandemic Activity in the Country, Province or Community	29
Pandemic Activity in the Country or Province, but No Pandemic Activity in the Community	29
Pandemic Activity in the Community.....	29
Pandemic Activity in the Home	30
3.1 Notify the local Medical Officer of Health or Designate of a Potential or Confirmed Outbreak.....	30
3.2 Implement Occupational Health/Infection Prevention and Control Measures	31
3.2.1 Droplet and Contact Precautions	32
3.2.2 Access to Personal Protective Equipment	32
3.2.3 Hand Hygiene	32
3.2.4 Masks	33
3.2.5 Eye Protection.....	33
3.2.6 Gloves	34
3.2.7 Gowning.....	34
3.2.8 Environmental Cleaning.....	34
3.2.9 Cleaning Resident Care Equipment.....	35
3.3 Notify Appropriate Individuals	35
3.4 Hold an Initial Outbreak Management Team Meeting.....	36
3.5 Monitor the Outbreak/Conduct Ongoing Surveillance.....	37
3.5.1 Resident Surveillance.....	37
3.5.2 Staff Surveillance	37
3.6 Implement Control Measures for Residents	38
3.6.1 Restrict Ill Residents to Their Room During the Outbreak	38
3.6.2 Cohort Residents/Restrict Residents to Their Unit During the Outbreak	38
3.6.3 Admissions, Re-admissions and Discharges	38
3.6.4 Medical Appointments	39
3.6.5 Transfers to Hospital	39
3.6.6 Transfer to Another Long-Term Care Home.....	39
3.6.7 Communal Meetings	39
3.7 Control and Support Measures for Staff and Volunteers	40
3.7.1 Deploying Staff	40
3.7.2 Supporting Staff.....	40
3.7.3 Reporting Influenza in Staff.....	40
3.7.4 Excluding Staff, Students, and Volunteers from the LTCH	40
3.7.5 Cohort Staff	40
3.7.6 Policies for Managing Staff who Work at Other Facilities.....	41
3.8 Control Measures for Visitors and Volunteers (including family)	41
3.8.1 Notifying Visitors and Volunteers.....	41
3.8.2 Visitor Restrictions.....	41
3.8.3 Visiting Ill Residents.....	42
3.8.4 Communal and Other Activities	42

3.9 Antiviral Distribution and Administration	42
3.9.1 Antiviral Storage, Security and Monitoring	42
3.9.2 Antiviral Medication for Prevention/Prophylaxis	43
3.9.3 Antiviral Medication for Treatment	43
3.9.4 Administration of Oseltamivir	43
3.9.5 Obtaining Reimbursement for Antivirals from the Drugs Programs Branch.....	43
3.10 Vaccine Distribution and Administration	43
3.10.1 Roles and Responsibilities	43
3.10.2 Immunization Strategy	44
3.10.3 Vaccine Storage and Security	44
3.11 Investigate the Outbreak	44
3.12 Review the Pandemic Outbreak	44
 Appendices	
Appendix 1: Pandemic Preparedness Checklist	45
Appendix 2: Antivirals and Vaccine	51
Appendix 3: MOHLTC Supplies Equipment Template: Care in the Home	58
Appendix 4: FRI Case Finding/Surveillance Protocol.....	59
Appendix 5: Forms	61

Preface

During the 20th century, the world experienced three influenza pandemics. The most deadly, the “Spanish Flu” in 1918-19 killed over 20 million people.

Public health experts predict that another influenza pandemic could happen any time. If an influenza pandemic does occur in Ontario, long-term care homes (LTCHs) will be affected. Because of their age and underlying medical conditions, most people living in LTCHs are at increased risk of complications from influenza. Viruses can be introduced into LTCHs by staff and visitors, and they spread easily in these closed communities. During influenza outbreaks in long-term care homes, as many as 70% of individuals (i.e., residents and staff) may become infected. The increased use of invasive devices, such as central lines, chronic respirators and feeding devices, contribute to the development of infections and complications (Canadian Pandemic Influenza Plan, Annex G, Patient Management in Long-Term Care Homes).

LTCHs across Ontario already have infection prevention and control programs in place to prevent and manage respiratory infection outbreaks, including seasonal influenza. They also have emergency plans. However, these plans and programs may not be adequate in the case of an influenza pandemic, so the Ministry of Health and Long-Term Care, in consultation with the long-term care sector and Community Care Access Centres, has prepared this *Guide to Influenza Pandemic Preparedness and Response in Long-Term Care Homes*.

1.1 How to Use the Guide

The purpose of this guide is to:

- guide and assist LTCHs before and during an influenza pandemic
- provide useful and practical information that will help LTCHs:
 - prepare for a possible influenza pandemic and develop consistent pandemic plans
 - detect the arrival of the pandemic strain in the home
 - respond to and manage an influenza pandemic in the home, should one occur.

The guide is divided into two parts:

- 1. Preparedness** – see section 2 -- provides information to help LTCHs prepare for an influenza pandemic. Use this part to help develop plans for an influenza pandemic.
- 2. Response** – see section 3 -- provides information to help LTCHs respond during an influenza pandemic.

**If an influenza pandemic has been declared in the country, province or community,
PROCEED IMMEDIATELY TO PAGE 29: RESPONSE.**

This guide should be used in conjunction with:

Any directives issued by the Ministry of Health and Long-Term Care (MOHLTC) during an influenza pandemic.

Preventing Febrile Respiratory Illnesses: Protecting Patients and Staff. Best Practices in Surveillance and Infection Prevention and Control for Febrile Respiratory Illness (FRI) for All Ontario Health Care Settings, Provincial Infectious Diseases Advisory Committee (PIDAC), Ontario Ministry of Health and Long-Term Care, 2005.

The Ontario Health Plan for an Influenza Pandemic, Ontario Ministry of Health and Long-Term Care, 2005.

A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, Public Health Division and Long-Term Care Homes Branch, Ontario Ministry of Health and Long-Term Care, October 2004.

Influenza Prevention and Surveillance Protocol for Ontario Long-Term Care Facilities, Ontario Ministry of Health and Long-Term Care 1999.

Routine Practices and Additional Precautions for Preventing the Transmission of Infections in Health Care, Health Canada 1999.

Useful links

Ministry of Health website:

<http://www.health.gov.on.ca/>

Public Health Agency of Canada website:

<http://www.phacaspc.gc.ca/influenza/index.html>

Acknowledgements

The Emergency Management Unit of the Ministry of Health and Long-Term Care would like to thank the individuals who attended the planning sessions for this document, prepared materials and reviewed drafts:

Carole Alexander
Long-Term Care Homes Branch – MOHLTC

Hafeeza Bassirullah
Emergency Management Unit – MOHLTC

Mark Breen
Emergency Management Unit – MOHLTC

Terrie Dean
CCAC Waterloo Region

Doug Gowans
Community Health Division – MOHTLC

Sue Guinard
Long-Term Care Homes Branch – MOHLTC

Tamara Johnson
St. Josephs' Villa – OANHSS

Brenda MacPherson
CCAC of York Region

Jenny McKay
Parkview Home

Caitriona O'Sullivan
Emergency Management Unit – MOHLTC

Joanne Rey
Infectious Diseases Branch – MOHLTC

Bobbie Rogan
Ontario Long-Term Care Association

Tina Sakr
Home Care and Community Support Branch –
MOHTLC

Lydia Stewart-Ferreira
Long-Term Care Homes Branch – MOHLTC

Allison Stuart
Emergency Management Unit - MOHLTC

Anne-Luise Winter
Infectious Diseases Branch – MOHLTC

The Emergency Management Unit would also like to thank the many other individuals who reviewed drafts of this document and provided expertise and advice.

1. Introduction

1.1 About Influenza

Influenza is a contagious respiratory illness caused by a group of viruses: Influenza Types A, B and C. Most seasonal influenza outbreaks and epidemics are caused by Types A and B; Type C rarely causes human illness. A highly infectious disease, influenza can be *directly* transmitted from person to person primarily when people infected with influenza cough or sneeze, and droplets of their respiratory secretions come into contact with the mucous membranes of the mouth, nose and possibly eyes of another person (i.e., droplet spread). It can also be transmitted *indirectly* when people touch contaminated hands, surfaces and objects (i.e., contact spread). The virus can survive for 24 to 48 hours on hard non-porous surfaces, for 8 to 12 hours on cloth, paper and tissue, and for 5 minutes on hands.

1.2 Seasonal Influenza vs Influenza Pandemic

An influenza pandemic will be different from seasonal influenza in several ways (see Table 1). During an influenza pandemic, there will be more people needing care, and fewer health care and essential service workers available to work. Existing respiratory outbreak and emergency plans should be reviewed to ensure they take into account the potential impact of an influenza pandemic.

Table 1: A Comparison of an Influenza Pandemic and Seasonal Influenza

Influenza Pandemic	Seasonal Influenza
Caused by a new strain of influenza A virus that can spread easily from person to person	Caused by a known circulating strain of influenza A virus
Can occur at any time of year	Occurs during flu season: between November and April
May strike in two or three waves, several months apart. Each wave may last two to three months	Peaks for a few months during the winter and then declines
Will take at least 4 to 5 months after the pandemic strain is identified to develop a vaccine	Annual vaccines are available and will provide some protection against circulating strains
Could infect between 30 to 50% of the population (The Ontario Health Plan for an Influenza Pandemic is based on a 35% attack rate.)	Infects 10 to 20% of the population yearly
Most people will have little or no immunity to the new virus, so there be more serious illness and a greater number of deaths	A portion of the population will have some immunity either because of previous exposure or immunization with the annual flu vaccine. Most people will not become seriously ill, and fewer will die
Could affect anyone, including health care providers and their families, severely disrupting the health care system	Affects mainly the very young and very old, and people who are immunocompromised; does not usually affect health system's ability to provide care
Could also affect other essential service workers and their families, and could disrupt those services	Does not usually disrupt a community's ability to provide essential services

1.3 Planning Assumptions

This guide for LTCHs is based on the following assumptions:

- An influenza pandemic will affect the entire health care system and the community. Hospitals, local public health units and other services will have limited capacity. LTCHs may not be able to rely on the same level of support they receive now from other parts of the health care system or from other community services during an outbreak.
- Pandemic influenza plans developed by individual LTCHs must be: coordinated with the plans of other organizations in their communities and local/regional pandemic plans; and consistent with the Ontario Health Plan for an Influenza Pandemic (OHPIP).
- The number of health care workers available to provide care may be reduced by up to one-third because of personal illness, concerns about transmission in the workplace, and family/caregiving responsibilities.
- Usual sources of supplies may be disrupted or unavailable.
- A vaccine will not be available for at least four to five months after the pandemic strain is identified. It will not be available in time for the first wave of illness but may be available in time to reduce the impact of the second wave. Once available, the vaccine will be in short supply and high demand.
- The only specific drug treatment option for influenza during a pandemic will be antiviral drugs, which must be started within 48 hours of the onset of symptoms. The efficacy of antivirals against the pandemic strain is unknown but, when antivirals are used to treat seasonal influenza, they have been shown to shorten the length of time people are ill, relieve symptoms and reduce hospitalizations. Although antivirals can be used as a preventative, they will be in short supply and high demand. Organizations will have to rely on traditional infection prevention and control practices (e.g., hand hygiene, appropriate personal protective equipment, separating sick individuals) as the main line of defense.
- Because Ontario will not have a large enough supply of either antivirals or vaccine (when it is first developed) for the entire population, the province will have to set priorities for who receives them. Ontario will follow the recommendations of the Federal/Provincial/Territorial Pandemic Influenza Committee (PIC) for priority groups for immunization and antiviral treatment and prophylaxis. During the course of the pandemic, priority groups may change based on the epidemiology of the pandemic strain (i.e., the nature of the virus, the people most affected).
- To meet community needs during a pandemic, resources – including staff, supplies and equipment – may have to be reassigned or shifted.
- Care protocols may change and practice may have to be adapted.
- LTCHs will need effective ways to communicate with residents' family and friends, in order to meet their needs for information but reduce the demands on staff.

1.4 Ethical Considerations

When developing their influenza pandemic plans, LTCHs should identify the ethical framework they will use to make difficult decisions about which services will be provided, how services will be provided, who will be allowed into the homes, and how limited resources will be used. For example:

- **Individual Liberty/Protection of the Public from Harm.** During a pandemic, it may be necessary to restrict individual liberty to protect the public from serious harm. When making decisions designed to protect the public from harm, LTCHs will weigh the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g., isolation). They will also ensure that all those involved are aware of the medical and ethical reasons for the measures, the benefits of complying, and the consequences of not complying.
- **Proportionality.** Restrictions on individual liberty and measures to protect the public from harm should not exceed the minimum required to address the actual level of risk or need in the community. LTCHs will use the least restrictive or coercive measures possible when limiting or restricting liberties or entitlements.
- **Privacy.** Individuals have a right to privacy, including the privacy of their health information. During a pandemic, it may be necessary to override this right to protect the public from serious harm; however, to be consistent with the ethical principle of proportionality, LTCHs will limit any disclosure to only that information required to meet legitimate public health needs.
- **Equity.** During a pandemic, LTCHs will strive to preserve as much equity as possible between the needs of residents with influenza and residents who need care for other diseases, and to establish fair decision-making processes/criteria. When homes have to identify residents and staff who will have priority access to antivirals, vaccines or other treatment, they will ensure that everyone is aware of the criteria used to make those decisions (see tables 3 and 4: priority groups for antivirals and vaccine during a pandemic). They will also be aware of the impact that these decisions may have on the home.
- **Duty to Provide Care/Reciprocity.** Health care workers have an ethical duty to provide care and respond to suffering. During a pandemic, demands for care may overwhelm health care workers and their institutions, and create challenges related to resources, professional practice, liability and workplace safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e., to their own health, family and friends). To support staff in their efforts to discharge their duty to provide care, LTCHs will strive to ensure the appropriate supports are in place (e.g., resources, supplies, equipment), provide support for staff to fulfill their personal/family responsibilities, take steps to ease the burden on staff and their families, and establish a mechanism to deal with staff concerns and work exemptions.
- **Trust.** Trust is an essential part of the relationship between organizations and their staff, between the public and health care workers, and among organizations within a health system. LTCHs will take steps to build trust with staff, families and other organizations before the pandemic occurs and to ensure decision making processes are ethical and transparent.
- **Solidarity.** Stemming an influenza pandemic will require solidarity among community, health care institutions, local public health units, and government. Solidarity requires good, straightforward communication and open collaboration to share information and coordinate health care delivery.
- **Stewardship.** LTCHs will be entrusted with governance over scarce resources, such as vaccines,

antivirals, equipment and health care workers. To ensure good stewardship of scarce resources, LTCHs will consider both the benefit to the public good and equity (i.e., fair distribution of both benefits and burdens). As part of stewardship, LTCHs will determine how resources will be allocated for residents who are at end of life.

- **Respect for Cultural Diversity/Beliefs.** LTCHs will strive to continue to respect residents' cultural values and religious beliefs throughout a pandemic.

Adapted from the *Ontario Health Plan for an Influenza Pandemic* (OHPIP) 2005.

1.5 Protecting Health Care Workers

During a pandemic – before an effective vaccine is available – the risks of health care staff acquiring influenza will be similar to the risks faced by the general population. This is due to:

- the ease with which respiratory illnesses such as influenza can pass from one person to another
- the large number of people in the community who will be infected and the high risk of community spread.

The Risk in the Workplace

As noted in 1.1, influenza is primarily transmitted *directly* from person to person when people infected with influenza cough or sneeze, and droplets of their respiratory secretions come into contact with the mucous membranes of the mouth, nose and possibly eyes of another person (i.e., droplet spread). Because the virus in droplets can survive for 24 to 48 hours on hard non-porous surfaces, for 8 to 12 hours on cloth, paper and tissue, and for 5 minutes on hands, people may acquire influenza *indirectly* by touching contaminated hands, surfaces and objects (i.e., contact-spread).

The issue of whether influenza can be spread by airborne transmission is controversial but, according to the Canadian Pandemic Influenza Plan, “there is no evidence of such transmission in humans”. In ordinary circumstances, influenza is not spread through airborne routes. In some high risk procedures that create aerosols (e.g., nebulized therapies, aerosol humidification, intubation), droplets containing virus may become aerosolized and spread through the air.

The risk to health care workers in the workplace is highest in settings where people first present with symptoms (e.g., physicians' offices, community health centres/clinics, emergency departments), in settings providing care for vulnerable people (long-term care homes), and in settings where staff are performing high risk procedures (i.e., high for providers, not necessarily for patients) that create sprays and splashes (e.g., nebulized therapies, aerosol humidification). In the workplace, steps can be taken to protect workers caring for patients with influenza. In fact, the risk can be reduced more easily in the workplace than out in the community.

Duty to Provide Care and Responsibility to Protect Workers

As noted in the ethical framework for decision making (see 1.4), health care workers have an ethical duty to provide care and respond to suffering. At the same time, society has an ethical responsibility to support health care workers who will bear the greatest burden (i.e., greatest risk) in protecting the public good. During a pandemic, workers' concerns about their own health or the health of their families may cause them to weigh their duty to provide care against competing obligations. The steps that the health care system and the broader society take to support health care workers can make it easier for them to fulfill their duty to provide care.

Under the ***Occupational Health and Safety Act***, organizations that employ health care workers have a

legal obligation to take all reasonable precautions to protect workers. Under the Regulation for Health Care and Residential Facilities, employers in health care facilities have a duty to establish measures and procedures to protect workers, including:

- control of infections
- immunization
- the use of disinfectants
- the handling, cleaning and disposal of soiled linen, sharp objects and waste.

Health care employers are expected to maintain healthy work environments. Employers, in consultation with the Joint Health and Safety Committee (JHSC) in the workplace, are required to develop these procedures and provide workers with relevant training.

In environments where people with infectious diseases are treated, there is no such thing as “total protection” or “zero risk” for patients, visitors or health care workers, but there are steps that health care settings can take to protect the system’s greatest asset – its workers – and significantly reduce the risk of providing care. The spread of influenza virus in health care settings can be prevented and controlled through the consistent use of best practices in surveillance and infection prevention and control for respiratory infections (see: *Preventing Respiratory Illnesses, Protecting Patients and Staff: Best Practices in Surveillance and Infection Prevention and Control for Febrile Respiratory Illness (FRI)*, developed by MOHLTC). If these practices are used consistently, health care workers will be protected while caring for patients with influenza.

To reduce the risk to staff of acquiring influenza in the workplace, all health care settings in Ontario are expected to:

- ensure all staff have the education, training and supervision they need to protect themselves and provide effective care (see 2.2)
- institute appropriate occupational health and infection prevention and control measures (see 3.2, 3.6, 3.7, 3.8)
- provide appropriate personal protective equipment (PPE) (i.e., masks, gloves, gowns) (see 3.2.2)

1.6 WHO Pandemic Periods and Phases

To help guide planning, the World Health Organization (WHO) has identified the phases of a pandemic (see table 2). For purposes of this guide, the Interpandemic and Pandemic Alert periods correspond to section 2 (i.e., Preparedness) and the Pandemic Period corresponds to the section 3 (i.e., Response).

Table 2: WHO Pandemic Periods and Phases

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

Source: World Health Organization, 2005.

* The distinction between phase 1 and phase 2 is based on the risk of human infection or disease from circulating strains in animals.

** The distinction between phase 3, phase 4 and phase 5 is based on the risk of a pandemic.

1.7 Emergency Management Roles and Responsibilities

An influenza pandemic will have an impact throughout society and will involve the broader emergency management system. Figure 1 illustrates the relationship between the health response to an influenza pandemic and the broader emergency response at the provincial level. Figure 2 illustrates the roles and relationships at the local or community level.

Figure 1: Emergency Management Roles and Relationships at the Provincial Level

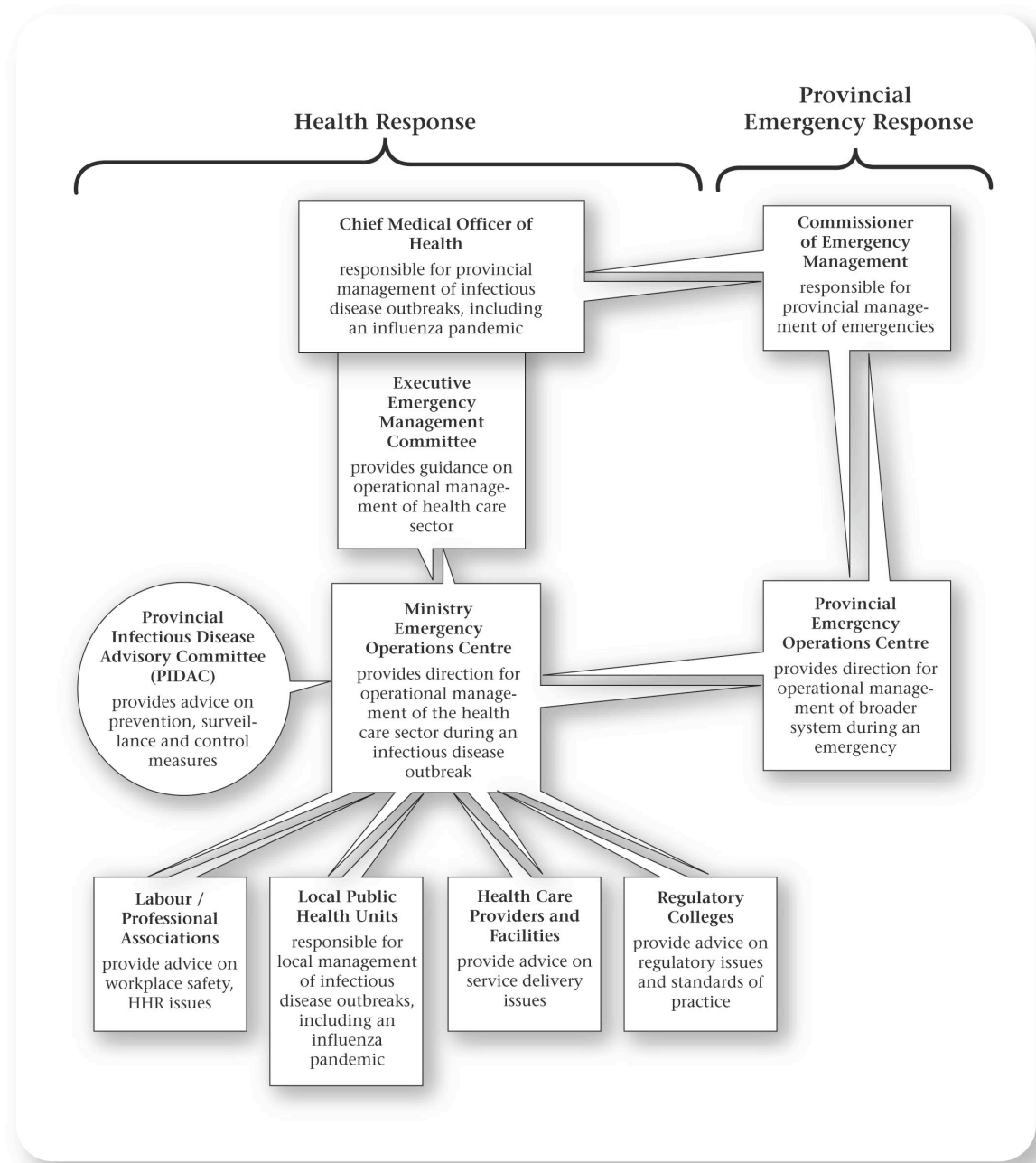
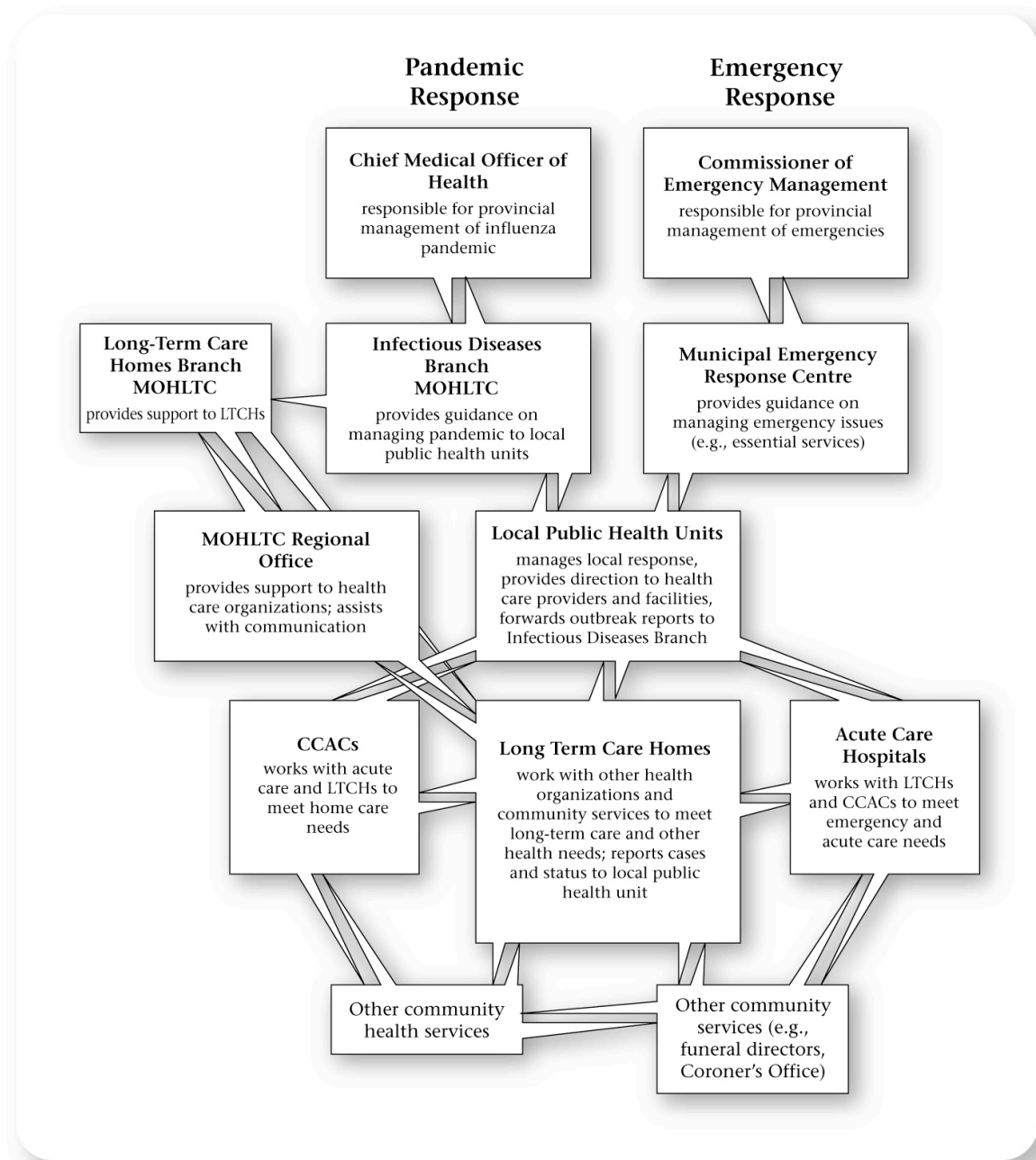


Figure 2: Emergency Management Roles and Relationships at the Community Level



2. Preparedness

Early in 2003, the Province of Ontario experienced first hand the impact of a contagious respiratory illness (i.e., SARS), which affected people's health and lives, put intense pressure on the health care system, and had devastating economic and social impacts in the broader community. That health emergency, which was contained and affected a relatively small number of people (i.e., 375 cases), highlighted weaknesses in our readiness to deal with a health threat. In the case of an influenza pandemic, appropriate preparedness and planning may reduce: the number of people infected (i.e., the extent of the outbreak), the severity of illness, the number of deaths, and the amount of socio-economic disruption.

Every part of the health care system must be prepared to mobilize resources quickly and effectively to limit the impact of an influenza pandemic.

See Appendix 1 for a Preparedness Planning Checklist for Long-Term Care Homes.

Preparedness involves measures that are put in place before an emergency occurs that will enhance the effectiveness of response and recovery activities, such as developing plans, tools and protocols; establishing communication systems; conducting training; and testing response plans.

2.1 Planning

Every LTCH should develop a plan for an influenza pandemic, which should be reviewed and updated annually or more frequently if required. These plans should be based on the outbreak and emergency plans already in place, and adapted to reflect the potential severity of an influenza pandemic.

2.1.1 Coordinate Planning with Other Health Organizations

Because an influenza pandemic will affect the whole community, LTCHs cannot plan in isolation. They should:

- connect with other health organizations in the community, including other LTCHs, hospitals, community care access centres (CCACs), home care providers, primary care providers, emergency medical services (for resident transfers), local public health units, laboratory services, pharmacies and regional infection control networks (where they exist)
- familiarize themselves with other organizations' plans and functions during a pandemic
- identify opportunities to collaborate/share resources during a pandemic
- identify possible scenarios and how they would be handled by the system (e.g., if the hospital is unable to accept residents from LTCHs, how will LTCH provide care? can well residents be moved to another site or level of care? how will the system make the best use of human

Goals of Pandemic Planning

1. To minimize serious illness and overall deaths through appropriate management of Ontario's health care system, and
2. To minimize societal disruption in Ontario as a result of an influenza pandemic

The focus of pandemic planning is to reduce the impact of influenza on individuals and society.

resources?)

- identify agencies that could provide staff (e.g., nursing agencies)
- work with partners, such as acute care hospitals, the Provincial Transfer Authorization Centre (PTAC), and Community Care Access Centres to develop criteria to determine who will be admitted to hospital (e.g., residents requiring life sustaining services, such as hemodialysis), who will be cared for in a LTCH, and who will be served by home care.

2.1.2 Review and Update Emergency Plans

Because an influenza pandemic is likely to cause social disruption and affect essential services, all LTCHs should review existing emergency and business continuity plans to ensure they take into account the extraordinary demands of an influenza pandemic.

2.1.3 Establish an Influenza Pandemic Outbreak Management Team and Communicate Chain of Command to Staff

To ensure staff know who is responsible in the event of a pandemic, LTCHs should establish an outbreak management team (OMT) to direct and oversee all aspects of an outbreak in the LTCH during an influenza pandemic.

The pandemic OMT should identify the people responsible in the event of an outbreak (i.e., chain of command). The title of the person authorized to manage an influenza pandemic (e.g., director of care) and an alternate (e.g., assistant director of care) should be posted on a bulletin board in an accessible area (e.g., staff lounge).

The OMT should include representatives who have decision making authority within the home as well as a representative from the local public health unit. Note: During a pandemic, the local public health unit may not be able to provide a representative for all LTCH OMTs.

2.1.4 Assess Residents' Care Needs

LTCHs should assess residents' care needs in order to identify: residents who could be discharged to family members in the event of an outbreak; residents whose needs could be met by home care; residents who must continue to be cared for in a LTCH; and residents who are likely to require acute care. They should also identify residents at highest risk of complications from influenza, and develop plans to limit the risk of exposing them to the pandemic strain (e.g., isolation, closing floors). LTCHs should develop a mechanism to keep these lists of residents by level of care up to date.

OMT Roles and Responsibilities

The following roles and responsibilities should be assigned to members of the OMT:

Chairperson. Responsible for coordinating team meetings, and delegating tasks – usually chosen in consultation with the Medical Officer of Health or designate.

Outbreak Coordinator. Responsible for ensuring all OMT decisions are carried out, and coordinates all activities required to investigate and manage the outbreak -- often the Infection Control Professional.

Media Spokespersons Responsible for giving information to members of the news media – can be a representative of the home and/or the public health unit.

Secretary. Responsible for setting meetings, notifies committee members of any changes. Records and distributes minutes of meetings.

The long-term care home should have assign a back-up person for each role during a pandemic.

2.1.5 Identify Essential Services/Services that Could Be Curtailed

During a pandemic, LTCHs will likely be short staffed, and will have to focus on delivering essential services. As part of the pandemic plan, the LTCH will identify:

- services that **MUST** be maintained to provide care and protect residents' health (e.g., life-maintaining medications and treatment, such as insulin and dialysis)
- services that could be reduced or curtailed, such as day programs, Wheels to Meals, community bathing program, clinics, therapy, appointments and recreational activities
- outside services scheduled to come in (e.g., occupational therapy, physiotherapy, dental services) that are essential and those that can be postponed

2.1.6 Identify Priority Groups for Access for Antivirals and Vaccine

Because antivirals and vaccine are likely to be in limited supply during a pandemic, the province will adopt the national strategic options for the use of antivirals and vaccine, including the guidelines for priority groups.

Antivirals

Table 3 lists Ontario's priority groups for antivirals. They are based on the preliminary priority groups identified by the Federal/Provincial/Territorial Pandemic Influenza Committee (PIC), and they may change depending on the characteristics of the pandemic strain (e.g., severity of illness, populations most affected) and the available supply of antivirals. The available supply will be directed to: people identified as being at increased risk of complications and death due to influenza and people whose skills and services are essential for the pandemic response.

Antivirals will be administered to priority groups simultaneously: that is, treatment of ill persons and prophylaxis of people providing essential services will occur at the same time.

Vaccine

Ontario's goal is to obtain enough vaccine for the entire population but, during the early stages of a pandemic, vaccine will likely be in short supply. In this situation, the province will follow the national recommendations for priority groups for influenza immunization, adapting them as required to meet provincial needs (See Table 4).

See Appendix 2 for: more detail on priority access to antivirals and vaccine, and for examples of the roles and functions considered "essential" during an influenza pandemic, and for an enumeration tool that LTCHs can use to identify the number of people (based on the duties they perform, rather than their position title) who may be considered for priority access to antivirals and vaccine. The enumeration process is designed to help organizations and the province plan for a pandemic; however, the final decision about priority access to antivirals and vaccine will not be made until the pandemic begins and more is known about the pandemic strain. Information about the enumeration tool is also available on the ministry website:

http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/enumeration_mn.html

Table 3: Priority Groups for Antivirals During a Pandemic

Priority	For Treatment	For Prophylaxis
1	<p>Persons hospitalized for influenza (within 48 hours of symptoms)</p> <p><i>Rationale: People who require hospitalization will be very ill, and at greatest risk of complications and death. Treatment with antivirals within 48 hours of symptoms can reduce the severity and duration of influenza.</i></p>	<p>Front line health care workers and key decision makers</p> <p><i>Rationale: The health care and public health sectors are the first line of defense in a pandemic. An effective response depends on maintaining essential health services.</i></p>
2	<p>Ill health care workers and first responders/emergency service providers</p> <p><i>Rationale: Treatment with antivirals within 48 hours of symptoms can reduce the severity and duration of influenza. This will allow workers to return to work more quickly.</i></p>	<p>Remaining health care workers</p> <p><i>Rationale: The health care and public health sectors are the first line of defense in a pandemic. An effective response depends on maintaining essential health services.</i></p>
3	<p>Ill high risk person in the community (within 48 hours of symptoms)</p> <p><i>Rationale: People at high risk are more likely to develop complications from influenza. Treatment with antivirals within 48 hours of symptoms can reduce the severity and duration of influenza.</i></p>	<p>Emergency/essential service workers</p> <p><i>Rationale: An effective response depends on maintaining essential community services.</i></p>
4	<p>Ill high risk residents in institutions</p> <p><i>Rationale: People at high risk are more likely to develop complications from influenza. Treatment with antivirals within 48 hours of symptoms can reduce the severity and duration of influenza. Treatment of high risk people in these settings can also help prevent an outbreak.</i></p>	<p>High risk residents of institutions</p> <p><i>Rationale: Prophylaxis will help control outbreaks within institutions.</i></p>
5		<p>Persons at high risk of being hospitalized for illnesses other than influenza</p> <p><i>Rationale: Reducing the risk/impact of influenza among people who are most vulnerable will reduce morbidity and mortality, as well as the demand on hospital resources.</i></p>
6		<p>Persons at high risk in the community</p> <p><i>Rationale: Reducing the risk/impact of influenza among people who are most vulnerable will reduce morbidity and mortality, as well as the demand on community health services and the need for hospitalization.</i></p>

Table 4: Priority Groups for Influenza Vaccine During a Pandemic

Priority	Group	Rationale
1	Front-line health care workers and key health decision makers*	The health care and public health sectors are the first line of defense in a pandemic. An effective response depends on maintaining essential health services.
2	Remaining health care workers*	
3	Emergency/essential service providers	An effective response depends on maintaining essential community services.
4	Persons at high risk of fatal outcomes (e.g., people living in nursing homes, LTCHs and similar settings, people with high risk medical conditions, people over age 65, children between the ages 6 and 24 months)	Reducing the impact of influenza outbreaks among people who are most vulnerable will reduce morbidity and mortality, and reduce health care demands.
5	Healthy adults**	Although healthy adults are at lower risk of developing severe outcomes from influenza, they make up the majority of the work force. Their absence in large numbers could have a direct economic impact and cause major socio-economic disruption. A high rate of influenza in healthy adults has the potential to overwhelm medical services and compromise care of those with complications. Vaccination could reduce the need for medical services and individuals could continue normal daily activities.
6	Children 24 months to 18 years of age**	Although children (> age 2) and youth are the least likely to experience severe outcomes from influenza, they play a major role in the spread of disease. The socio-economic impact of illness on children would be indirect, as adults would have to leave work to care for ill children who are absent from school.

Notes to Table 4:

Priority groups may change, based on recommendations from NACI, depending on the demographics and age-related morbidity and mortality (i.e., epidemiology) of the pandemic strain

* The guidelines developed by the Pandemic Influenza Committee of the Public Health Agency of Canada combine all health care workers into one category for vaccination. Although Ontario's goal is to provide vaccine for all health care workers, it may not be possible to do this – particularly in the early stages of a pandemic when vaccine may be in short supply – so Ontario has divided health care workers into two groups: front-line providers or people providing direct care for patients with influenza who would have first priority; and the remaining health care workers.

**A decision to vaccinate healthy adults and healthy children (Groups 5 and 6) depends on an adequate supply of vaccine. A much larger amount of vaccine would be required for these groups than for Group 4.

2.1.7 Storage and Tracking Systems for Antivirals

During a pandemic, the Ministry Emergency Operations Centre (MEOC) will be responsible for coordinating the distribution of antivirals and vaccine to local public health units across the province, and local public health units will be responsible for coordinating the distribution of antivirals and vaccine among health care organizations at the local level.

LTCHs must have the capacity to safely store antivirals and monitor distribution. (Note: vaccine distribution will be coordinated by the public health system. Vaccine supplies are unlikely to be stored or distributed by LTCHs.)

Long-term care home pandemic plans should:

- identify the person responsible for receiving, storing and tracking the use of antivirals
- identify where antivirals will be stored, and how the home's supply will be kept secure
- have a contingency plan in case of power failure or equipment malfunction
- establish medical directives to administer antivirals and vaccine (i.e., who can administer and sign off on antivirals)
- obtain consent from residents or their decision makers for treatment with antivirals and/or immunization during a pandemic
- set out the role of the pharmacy on contract with the LTCH in providing access to antivirals and back up services
- describe the mechanisms the home will use to track who receives antivirals and vaccine, and to monitor antiviral and vaccine uptake, effectiveness and adverse reactions and resistance to antivirals.

(For more information on the storage and distribution of antivirals and vaccine, see OHPIP, Appendix 8, Ontario Emergency Mass Vaccination/Prophylaxis Plan.)

2.1.8 Identify Required Supplies/Alternative Supply Chains

As part of preparedness planning, LTCHs should identify the type and quantity of supplies (other than antivirals and vaccine) they will need, and purchase and maintain a one-month stockpile. See Appendix 3 for a supplies and equipment template developed by the Ministry of Health and Long-Term Care.

During a pandemic, traditional supply chains may be disrupted. For example, a supplier in another jurisdiction may have to give priority to local companies. During the preparedness phase, LTCHs should:

- talk to suppliers about their ability to deliver during a pandemic
- review systems in place to ensure adequate supplies (e.g., environmental cleaning supplies, food, medications, oxygen concentrators)
- establish relationships with alternative suppliers/sources, including: equipment suppliers, food suppliers, medical suppliers, pharmacies, oxygen suppliers, attending physicians and any other health care providers who provide contracted services to the home (e.g., physiotherapists, occupational therapists).

2.1.9 Identify/Train Human Resources

During a pandemic, LTCHs are likely to experience staff shortages, and may have to take

extraordinary measures to continue to provide care for residents. The Ontario Health Plan for an Influenza Pandemic (OHPIP) supports a skills-based approach (for more information, see OHPIP, pp. 78-83). As part of their planning, LTCHs should identify:

- the skills required to meet residents' needs (see 2.1.3), including providing care for residents who develop influenza
- the direct care staff who have those skills or who could be trained to take on more responsibilities within their scope of practice
- strategies that could be used to increase capacity (e.g., contracting staff from external agencies, extending working hours, calling staff back to work)
- other staff (e.g., clerical, housekeeping) who could be trained to assist with care (e.g., feeding)
- family members who could be trained to help with care and daily living activities (e.g., how to give a bed bath and assist with feeding and toileting)
- other organizations in the community that might be able to provide workers with the appropriate skills
- any labour (i.e., union), insurance or liability issues the LTCH would have to address if it altered staff roles or used temporary workers and volunteers
- the supports that staff and other workers may need to be able to work (e.g., transportation, accommodation, assistance with child care and other family responsibilities).

LTCHs should engage members of the Occupational Health and Safety Committee and the union (e.g., the bargaining agent) in pandemic planning to ensure that their plans include appropriate practice, communication and education (see 2.2).

2.1.9 Review and Update Communication Plans

Most LTCHs will already have established plans and procedures for communicating with residents, residents' families, staff and media during an outbreak, as well as with other organizations in the community (e.g., local public health units, the coroner's office, funeral directors). These plans should be reviewed to ensure that they will be appropriate during a pandemic. Homes should ensure they maintain up-to-date contact lists for staff and residents' families/next of kin or caregivers.

To ensure that all parts of the health system are communicating consistent messages, LTCHs should use influenza fact sheets and other materials provided by the local public health unit or the MOHLTC, including Important Health Notices. They should also ensure they have an alternate or back up system of communication.

2.1.10 Review Security and Physical Plant

During a pandemic, LTCHs may require additional or different security procedures, such as the ability to lock down the facility and to safeguard antiviral supplies. They should also make provisions to manage traffic flow into and within the home.

2.1.11 Review and Update Policies

LTCHs are already required to develop and maintain policies designed to prevent and manage respiratory infections and outbreaks. These policies must be based on current directives, guidelines, protocols, and policies, and consistent with relevant legislation, standards and criteria

as outlined by the MOHLTC, the local public health unit, and other appropriate sources. As part of pandemic planning and preparedness, LTCHs should review their policies to ensure they address:

- procedures for surveillance and early detection of a pandemic strain of influenza in the home, and management of an outbreak including how the composition and mandate of a pandemic Outbreak Management Team (OMT) will be different from current outbreak policies
- policies for medical testing and lab samples during a pandemic that are consistent with provincial guidelines (for more information, see OHPIP, Laboratory Services)
- exclusion policies during a pandemic. Note: these may differ from current outbreak management policies. Because there will be no vaccine at the beginning of the pandemic, non-immunized staff will **NOT** be excluded from providing care, provided they wear appropriate PPE and perform frequent hand hygiene. Because of anticipated staff shortages, staff who develop influenza may be allowed to work, but they will be restricted to non-resident care or to the care of residents with influenza-like illness (ILI)
- a staffing contingency plan that takes into account the varying levels of available staff during a pandemic due to illness, family responsibilities, unwillingness to work or take antivirals, and staff with medical contraindication to antivirals
- a staffing plan to address adequate caregiver to resident ratios, and to identify other staff and individuals who could be trained to ensure the home is able to provide essential services
- a policy on antiviral storage, how limited supplies will be distributed (based on priority group recommendations), and how staff will be expected to prove they have taken antivirals as directed or received antivirals from another health care facility
- a policy on vaccine distribution and administration once a vaccine becomes available
- plans to identify residents who will need life-maintaining medication and treatment (e.g., insulin, dialysis)
- a policy on the steps that the LTCH will take to protect workers (e.g., education, PPE, access to antivirals, supports for family responsibilities, psychosocial support)
- obtaining consent for prophylaxis or treatment with antivirals from residents or substitute decision-makers
- obtaining pre-approved orders from physicians or a “medical directive” signed by the Medical Director to administer antivirals and vaccine
- strengthening lines of communication between the home, the local public health unit, pharmacy and laboratory
- maintaining effective communication with residents, Residents’ Council, families of residents, Family Council, staff and the media
- annual review of policies related to outbreak prevention and control.

2.2 Immunization Policy

Although immunization against seasonal influenza will not protect residents or staff from a pandemic strain, it may protect them from circulating strains of influenza and help them maintain their health. Ontario will continue to provide a universal seasonal influenza immunization program during a pandemic until such time as those resources have to be redirected to manage the pandemic.

Each home must have an immunization policy for seasonal influenza and pneumococcal disease, as well as for other vaccine-preventable diseases, for residents, staff and all persons carrying on activities within the home, and communicate the policy clearly to staff and residents.

2.2.1 Residents

Residents should receive annual influenza vaccination, unless contraindicated. Residents should also receive at least one dose of pneumococcal vaccine during their lifetime.

If the influenza immunization status of a resident is not available or unknown, the resident should be considered unvaccinated, and vaccination should be offered.

The immunization record of the resident should be retained in an accessible part of their health record. If the resident is being transferred, the receiving health care facility should be informed about his/her immunization status.

2.2.2 Staff and Volunteers

Annual immunization against influenza should be required for all persons carrying on activities in the LTCH unless medically contraindicated. This includes employees, students, attending physicians, and both health care and non-health care contract workers and volunteers.

The home's policy for staff and volunteer immunization should be consistent with the recommendations in the *Influenza Prevention and Surveillance Protocol for Ontario Long-Term Care Facilities*²¹ and of the Provincial Infectious Diseases Advisory Committee in *Preventing Febrile Respiratory Illnesses Protecting Patients and Staff. Best Practices in Surveillance and Infection Prevention and Control for Febrile Respiratory Illness (FRI) for All Ontario Health Care Settings (2005)* which states:

“All health care settings should have staff immunization policies in place consistent with the Ontario Hospital Association/Ontario Medical Association joint Influenza Surveillance Protocol for Ontario Hospitals”³⁴. These policies should establish annual influenza immunization as a standard of care and set out the steps to protect patients and staff (e.g., reminding staff about the importance of annual immunization, documenting each person's immunization status, excluding nonimmunized staff from work during [seasonal influenza] outbreaks).

“During a [seasonal] influenza outbreak, clinical infection rates range from 10% to 20% in the general community to >50% in closed populations, such as patients/residents in hospitals and long-term care homes. To protect vulnerable patients during an outbreak, staff who have confirmed or presumed influenza or who have not been immunized and are not taking antiviral

Health care workers involved in direct resident care should consider it their responsibility to provide the highest standard of care, which includes undergoing annual influenza vaccination. In the absence of contraindications, refusal of health care workers who are involved in direct resident care to be immunized against influenza implies failure in their duty of care to their patients

National Advisory Committee on Immunization (NACI) 2005/06 Statement on Influenza Vaccination).

² Ontario Ministry of Health. *Influenza Prevention and Surveillance Protocol for Ontario Long-Term Care Facilities*. November 1999.

³ Ontario Hospital Association & Ontario Medical Association Joint Committee on Communicable Disease Surveillance Protocols. *Influenza surveillance protocol for Ontario hospitals*. Rev.ed. [Toronto, Ont.]: Ontario Hospital Association; 2004. www.oha.com.

prophylaxis should be excluded from providing direct patient care.⁵ Antiviral prophylaxis should not replace annual influenza immunization. Immunization is the primary tool in preventing the spread of influenza.” (Note: exclusion policies may change during an influenza pandemic.)

All staff who receive vaccine for seasonal influenza from a source other than the LTCH must provide proof of influenza immunization. Only the following should be accepted as proof of influenza immunization:

- a personal immunization record documenting receipt of the current season’s influenza vaccine signed by a health care professional or,
- a signed physician’s note indicating immunization or,
- documented immunization from another home or institution.

If this documentation is not available, the LTCH should not consider the staff member immunized and should offer the person influenza immunization.

2.2.3 Visitors

Visitors (including families) to the home should have their annual influenza immunization. However, it is not the responsibility of the home to verify the immunization status of visitors and family beyond informing them using appropriate visible signs.

2.2.4 Immunization Status Reports

Administrative staff must keep an updated list of staff and resident vaccination status throughout the influenza season. Each year, the home must report immunization status of residents, staff, and volunteers as of November 15th to the local medical officer of health by December 1st.

2.3 Surveillance

Surveillance is an essential component of any effective infection prevention and control program. It is unlikely that the spread of a pandemic strain into Ontario will first be detected in a LTCH but, because residents are highly vulnerable, an influenza pandemic could spread quickly and easily from the community into the long-term care environment.

2.3.1 Goal of Surveillance in Long-Term Care

To ensure early identification of a potential outbreak or an outbreak in its early stages so that control measures can be instituted as soon as possible to protect residents and staff.

2.3.2 Responsibility for Surveillance

The designated Infection Control Professional (ICP) is responsible for surveillance and outbreak management activities. In the ICP’s absence, a competent person must be designated to perform these functions, including on weekends and during holiday periods.

2.3.3 Target Groups for Surveillance

Surveillance should be done for: residents; staff, students and volunteers; and families and visitors. Surveillance for FRI should be ongoing year round, and not just during influenza season

⁵ National Advisory Committee on Immunization (NACI). Statement on influenza vaccination for the 2005-2006 season. An advisory committee statement. *Can Commun Dis Rep.* 2005; 31(ACS-6):1-30.

(i.e., November to April). LTCHs should make FRI surveillance an integral part of their infection prevention and control program.

i. Resident Surveillance

LTCHs are required to do continuous home-wide surveillance to establish baseline levels of infection throughout the year. Infection rates above the baseline may indicate a seasonal influenza outbreak or the arrival of the pandemic strain in the home. Homes should maintain an ongoing surveillance program, which would be enhanced when influenza activity is reported in the community. The surveillance program would include:

- screening of all new admissions using the FRI protocol (see Appendix 4)
- ongoing assessment of residents for signs and symptoms of influenza-like illness.

As part of an effective surveillance program, LTCHs must be able to recognize outbreaks during off-hours (e.g., weekends, holidays). All staff who provide direct care must be aware of the symptoms of respiratory illness, the criteria for a suspected and confirmed outbreak, and the procedures for reporting to the ICP.

Surveillance programs should:

- be sensitive enough to identify sentinel events and trends
- include analysis of surveillance data by the ICP which will be used to trigger actions to reduce or eliminate disease transmission
- include surveillance strategies that reflect community disease prevalence and the unique epidemiology of infection in long-term care.

Whenever there are **two cases of acute respiratory tract illness within 48 hours on one unit**, an outbreak should be suspected and tests should be done to determine the causative organism if appropriate. (Note: During an influenza pandemic, lab testing to confirm a diagnosis may not be feasible. See OHPIP, Laboratory Services.) The clinical presentation of influenza in an elderly, fully immunized population can differ from the usual clinical presentation of influenza (see box). Note: The clinical presentation of the pandemic strain may also be different, depending on the epidemiology of the virus. Public health authorities will provide a case definition.

The ICP will report any potential outbreak or declared outbreak to the local public health unit.

ii. Staff, Student and Volunteer Surveillance

LTCHs should conduct surveillance for FRI among staff, students and volunteers throughout the year. All staff, students and volunteers should be aware of early signs and symptoms of respiratory infection. LTCHs should establish a clear expectation to not come into work when ill with FRI, and support this expectation with appropriate attendance management policies. As discussed on page 22, this policy may change during a pandemic.

Influenza-like Illness (ILI)

Influenza-like illness includes:

- upper respiratory tract infections
- pneumonia
- other lower respiratory tract infections

Typical symptoms include fever, sore throat, cough, shortness of breath and body aches. For suspected influenza outbreaks, LTCHs may consider adding the following symptoms: abnormal temperature for the resident or a temperature $\leq 35.5^{\circ}$ or $\geq 37.5^{\circ}$, tiredness (malaise), muscle aches (myalgia), loss of appetite, headache, and chills.

Note: elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection so the presence of new onset cough or shortness of breath may be enough to trigger further assessment

As part of the surveillance program, staff, students and volunteers are expected to report ILI to their supervisor or to Employee Health, who will inform the ICP or designate of cases/clusters of employees/contract staff/volunteers who are absent from work for 72 hours with ILI. To protect confidentiality, the information should be reported non-nominally (without using names). This will be particularly important if a pandemic is declared.

The ICP will report clusters of ILI in staff or volunteers to the local public health unit.

As a general guideline: "Health care workers have a responsibility to their patients and colleagues regarding not working when ill with symptoms that are likely attributable to an infectious disease. This includes staff with influenza-like illness, febrile respiratory illness, gastroenteritis and conjunctivitis."

Ontario Hospital Association & Ontario Medical Association Joint Committee on Communicable Disease Surveillance Protocols, 2004.

In addition to reporting to public health, LTCHs are also required to alert infection control and occupational health services to any possible break in infection control procedures and any occupational risks to workers. Workers, infection control and occupational health services (OHS) work together to protect worker health and safety. The following summarizes reporting requirements for FRI:

- Workers who develop FRI symptoms report their condition to their OHS or delegate
- Infection control alerts OHS or delegate about any clusters of respiratory illness in patients so OHS can monitor staff
- OHS reports any clusters of FRI in staff to infection control (to protect employees' right to confidentiality, these reports are non-nominal)
- Employers report to the Joint Health and Safety Committee or delegate any occupationally acquired infection
- Any occupationally acquired infection must be reported to the Ministry of Labour (for investigation) and to the Workplace Safety and Insurance Board within 72 hours.

iii Family Members and Visitor Surveillance

Family members, friends, contractors – anyone entering or carrying on activities in the LTCH – should self screen for symptoms of FRI each time they enter. Signs and hand hygiene stations should be posted at all entrances instructing family members and visitors to:

- perform hand hygiene
- self-screen for symptoms of FRI (i.e., new cough, new shortness of breath, fever)
- not to enter if they have respiratory symptoms.

If possible, LTCHs should also ask all family members and visitors to sign in and out, so they have a record of who has been in the home in the event of an outbreak.

2.3.4 Role of Public Health

The local public health unit will provide advice on surveillance programs. They will also receive reports about FRI activity, including ILI, in the home, and provide information to the home on FRI activity, including ILI, or on pandemic activity in the community.

The Medical Officer of Health or designate will investigate any potential respiratory outbreak in a long-term care home. The Medical Officer of Health or designate is responsible for declaring an influenza outbreak and for disseminating information about pandemic activity in the community.

The Medical Officer of Health may release to the media or others as much information (including

the name of the home) as is necessary to decrease the risk of disease transmission to the community and to other homes within the local public health unit's jurisdiction.

2.4 Education

Preparedness should include ongoing education of staff, volunteers, residents and residents' families about influenza and the home's pandemic plan. A significant amount of education will focus on infection prevention and control practices and measures to protect the health of staff and residents. The home's Infection Control Professional, in collaboration with the Occupational Health and Safety Committee, is responsible for developing education plans and providing training.

2.4.1 Education Plans

As part of pandemic planning, LTCHs should develop an education plan that includes:

- the person/position responsible for the training/education program
- the education required for staff, including staff who do not routinely care for residents but might have to during a pandemic
- education for volunteers
- education required for residents, the Resident's Council, families and the Family Council, which may include training family members to assist with some aspects of care during a pandemic (e.g., bed baths, assisting with feeding and toileting)
- education for visitors
- methods for training staff and volunteers quickly for new and altered roles (e.g., have job descriptions and job action sheets been developed?)
- approaches to training (e.g., team-based approaches that will ensure any temporary workers receive appropriate support and supervision, and cross training to ensure staff are able to cover one another's duties, such as peritoneal dialysis)
- frequency of training (e.g., during orientation, then annually – or more frequently if threat of a pandemic is imminent)
- training resources (e.g., pamphlets, fact sheets, formal presentations, public awareness campaigns). Every effort should be made to ensure that education provided by the LTCH is consistent with that provided by other homes and other health care organizations in the community and province.

2.4.2 Education Programs

Education and training programs for all staff and residents should include (but not be limited to):

- the home's influenza pandemic plan
- the importance of hand hygiene and proper hand hygiene technique
- appropriate cleaning and disinfection of equipment (i.e., any equipment that is shared between residents must be cleaned and disinfected after each use)
- appropriate use of PPE which includes application, removal and disposal of gloves, gowns, eye protection, and surgical masks
- risks associated with infectious diseases such as FRI -- including ILI

- benefits of case finding/surveillance
- principles and components of routine infection control practices
- risks of transmission
- procedures that are considered high risk and why
- individual staff responsibility to keep other staff and residents safe
- the employers' responsibility to protect workers health
- risks, benefits, and myths regarding influenza immunization
- information about influenza morbidity, mortality, transmission, as well as prevention of influenza, and the requirement for annual influenza vaccination
- the home's annual immunization and exclusion policy for staff and visitors
- changes to exclusion policies during a pandemic and why.

3. Pandemic Response

Response Level by Pandemic Phase

A home's level of response will depend on the phase of the influenza pandemic worldwide as well as the level of threat in the community. To help ensure an appropriate level of response, Ontario has divided the WHO Phase 6 – Pandemic Activity – into three stages.

No Pandemic Activity in the Country, Province or Community

If an influenza pandemic has been declared elsewhere in the world, but there is no pandemic activity in the country, province or community, LTCHs can continue to use a passive approach to surveillance, which includes:

- allowing family members and visitors to self-screen
- looking for ILI symptoms in residents while providing routine daily care or activities
- staff reporting ILI symptoms to their supervisor or Employee Health.

Residents with ILI symptoms should be noted on the daily surveillance form. This form should be easy to use and include patient identification and location, date of onset of symptoms, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the ICP each day. Any suspected outbreak should be reported immediately to the ICP.

Pandemic Activity in the Country or Province, but No Pandemic Activity in the Community

When there is pandemic activity in the country or province, the LTCH will take a more active approach to surveillance, including:

- having a receptionist or volunteer screen family members and visitors
- actively seeking out signs or symptoms in residents by, for example:
 - conducting unit rounds
 - reviewing unit reports, which will provide information on any elevated temperatures
 - reviewing physician/staff communication books
 - reviewing medical and/or nursing progress notes on the residents' charts
 - reviewing pharmacy antibiotic utilization records
 - reviewing laboratory reports
 - asking unit staff for verbal reports, based on their clinical observations

All available sources of information within the home may contribute to the surveillance activities. The method used by each home should be practical in that setting. The ICP or designate will review the results of surveillance data for any signs of the pandemic strain. At this stage in the pandemic, the ICP will continue to use the normal reporting procedures to report to the local public health unit.

Pandemic Activity in the Community

If the pandemic has spread into the area, the local public health unit will notify the LTCH.

The LTCH will:

- activate its pandemic plan
- activate its emergency plan if appropriate (e.g., there is a loss of essential community)

- services)
- maintain active surveillance, using outbreak reporting forms provided by local public health units (under development at the time this guide was written)

Pandemic Activity in the Home

When an outbreak of the pandemic strain is **suspected or confirmed** in the home, the LTCH will take the following steps:

1. Notify the local Medical Officer of Health or Designate
2. Implement infection prevention and control measures
3. Notify appropriate individuals
4. Hold an initial meeting of the pandemic OMT
5. Monitor the outbreak//Continue ongoing surveillance
6. Implement control measures for residents
7. Implement control and support measures for staff and volunteers
8. Implement control measures for visitors
9. Distribute antivirals if available
10. Distribute vaccine if available
11. Investigate the outbreak
12. Review the outbreak

Note: Steps 1 through 6 will occur simultaneously. The following sections describe the activities involved in each step.

3.1 Notify the local Medical Officer of Health or Designate of a Potential or Confirmed Outbreak

The LTCH will:

- notify the Medical Officer of Health or designate by phone about the potential or confirmed outbreak
- submit the outbreak reporting forms to the Medical Officer of Health or designate by fax (Note: Faxes will be used until electronic reporting systems are established.)
- give the Medical Officer of Health or designate the name of the primary ICP and back ups at the home responsible for the outbreak investigation along with their contact information

Definition of Respiratory Outbreak

- Two cases of respiratory tract illness, one of which is laboratory confirmed influenza
OR
- Three cases of acute respiratory tract illness occurring within 48 hours in a geographic area (e.g., unit, floor)
OR
- More than two units having a case of acute respiratory illness within 48 hours

The Medical Officer of Health (MOH) or designate is responsible for declaring an outbreak of influenza caused by the pandemic strain in a LTCH, although the Medical Director of the home can also declare an outbreak. The MOH is also responsible for notifying:

- the Chief Medical Officer of Health or designate
- adjacent public health units
- other health organizations and providers in the community, including the CCAC.

- report the initial control measures that have been instituted
- request an Investigation Number (formerly referred to as an Outbreak Number) and record it on all laboratory submission forms (this is an eight or nine digit number assigned by the local public health unit)
- discuss with the local public health unit if and which residents should be tested (e.g., only residents with acute symptoms early in the pandemic), how to obtain sampling kits, how many and which specimens will be collected during the initial investigation, and how they will be stored and submitted to the laboratory
- notify the MOHLTC regional office and continue to activate its pandemic plan and, if necessary, its emergency plan.

Note:

In order to track outbreaks, investigation/outbreak numbers will continue to be assigned. Once the local public health unit has confirmed the presence of the pandemic strain in the community, nasopharyngeal (N/P) swabs may no longer be required. If N/P swabs are required, the local public health unit will be responsible for supplying the home with swabs.

Some laboratory services may be curtailed during a pandemic so testing requirements may be different than during an outbreak of seasonal influenza.

Health units will notify the Public Health Laboratory of the lab testing if required (i.e., complete the laboratory notification sheet, fax it to the laboratory, and follow up with a phone call).

All specimens must include the patient's name, the home's name and the Investigation Number. The Public Health Laboratory will not process incompletely labeled or leaking specimens.

3.2 Implement Occupational Health/Infection Prevention and Control Measures

In closed environments, like LTCHs, there is no such thing as “total protection” or “zero risk” from infectious diseases for residents, visitors or staff; but LTCHs can take steps that will help protect staff and residents, and significantly reduce the risk of providing care.

The spread of influenza virus in health care settings can be prevented and controlled through the consistent use of droplet and contact precautions and other best practices in surveillance and infection prevention and control for respiratory infections (see: *Preventing Respiratory Illnesses, Protecting Patients and Staff: Best Practices in Surveillance and Infection Prevention and Control for Febrile Respiratory Illness (FRI)*, developed by MOHLTC). If these practices are used appropriately and consistently, health care workers will reduce their risk of contracting influenza while caring for residents with ILI.

The appropriate level of precaution should be driven by the procedure being undertaken and the resident's symptoms. Infection control programs should reinforce the importance of droplet and contact precautions for staff providing direct care. They should also ensure that staff receive periodic

Implement Infection Prevention and Control Measures

Implement droplet and contact precautions and control measures immediately.

Notify all staff quickly of the potential or confirmed outbreak.

Make supplies (e.g., hand sanitizer, masks, eye protection) available as necessary.

Reinforce the need for proper hand hygiene before and after providing care to each resident.

Enforce appropriate use and removal PPE by staff, volunteers and family members providing direct care to ill residents.

training on the use of these precautions.

Resources:

- *Preventing Febrile Respiratory Illnesses: Protecting Patients and Staff*, Best Practices in Surveillance and Infection Prevention and Control for Febrile Respiratory Illness (FRI) for All Ontario Health Care Settings, Ministry of Health and Long-Term Care, 2005.
http://www.health.gov.on.ca/english/providers/program/infectious/diseases/best_prac/bp_fri_092805
- *Infectious Diseases. Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care* – Revisions of Isolation and Precaution Techniques, 1999. Canada Communicable Disease Report 1999; 25(Suppl 4): 1-142 Available online at: <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/99pdf/cdr25s4e.pdf>.

3.2.1 Droplet and Contact Precautions

Precautions to prevent and control the spread of droplet spread illnesses include:

- hand hygiene (i.e., using alcohol-based hand sanitizer or washing hands: before seeing the resident; after seeing the resident and before touching the face; and after removing and disposing of PPE)
- a surgical/procedure mask covering the worker's nose and mouth when providing direct care within one metre of the resident
- protective eye wear when providing direct care within one metre of the resident
- examination procedures that minimize contact with droplets (e.g., sitting next to rather than in front of a coughing resident when taking a history or conducting an examination)
- appropriate gloves when the worker is likely to have contact with body fluids or to touch contaminated surfaces
- gowns during procedures and patient care activities where clothing might be contaminated
- any communal or shared equipment must be cleaned and disinfected after use.

Criteria for Selecting Masks

- Securely covers the nose and mouth
- Substantial enough to prevent droplet penetration
- Should be able to perform for a minimum of 45 minutes

Criteria for Selecting Eye Protection

- Eye protection must provide a barrier to splashes from the side
- May be safety glasses or face shields
- May be single use disposable or washable before reuse
- Prescription eye glasses are not acceptable as eye protection

Criteria for Selecting Alcohol-based Hand Sanitizer

- 60% to 90% alcohol (isopropanol or ethanol)

3.2.2 Access to Personal Protective Equipment

All LTCHs must have accessible hand hygiene stations in appropriate locations, and signage instructing all staff, residents, visitors and volunteers on when and how to practice hand hygiene.

LTCHs must ensure that staff have quick easy access to PPE required for droplet and contact precautions (i.e., alcohol-based hand sanitizer, surgical masks, eye protection, gloves, gowns). PPE kits should be distributed throughout the home.

3.2.3 Hand Hygiene

Hand hygiene is the most important measure in preventing the spread of all infections, including influenza. Staff, volunteers and residents should be instructed in proper hand hygiene.

Staff and Volunteers

Staff and volunteers should perform hand hygiene:

- before direct contact with a resident; after any direct contact with a resident and before touching the face; and after removing and disposing of PPE – including gloves
- before performing invasive procedures
- between certain procedures on the same resident where soiling of hands is likely, to avoid cross-contamination of body sites
- after contact with blood, body fluids, secretions and excretions
- after contact with items known or likely to be contaminated with blood, body fluids, secretions and excretions, including respiratory secretions (e.g., oxygen tubing, masks used tissues and other items handled by the resident)
- before preparing, handling, serving or eating food and before feeding a resident.

Waterless alcohol-based hand sanitizer is as effective as handwashing if hands are not visibly soiled. If hands are visibly soiled, they must be washed with soap and running water. If soap and running water are not available, cleanse hands first with detergent-containing towelettes to remove visible soil, and then use an alcohol-based hand sanitizer.

Sinks that residents use may be contaminated and should not be used by staff and volunteers for hand hygiene unless no other alternative is available. If staff or volunteers must use a resident's washroom, they should take care to avoid contamination, and use an alcohol-based hand sanitizer after handwashing.

Residents

Hand hygiene is essential for residents at all times. Residents' hands should be cleaned frequently but especially after using the bathroom, and before meals.

3.2.4 Masks

Note: The term "mask" refers to **a surgical or procedure mask**, unless explicitly stated otherwise.

Staff and volunteers should wear masks covering the nose and mouth when providing direct care within one metre of a resident with ILI.

Whenever a resident with ILI is not in his/her room (e.g., during transfer to another facility), the resident should wear a surgical mask, if tolerated.

Masks should be changed if they become wet, or contaminated by secretions.

Staff wearing masks must remove their mask before caring for another resident, and when leaving the resident's dedicated space/room.

Masks should be handled only by the strings/ties, to prevent self contamination.

Masks should be changed according to the manufacturer's recommendations.

3.2.5 Eye Protection

Eye protection includes the use of safety glasses, goggles, and face shields. It does not include personal eye glasses.

Eye protection should be worn when providing direct care within one metre of a resident with

ILI.

Safety glasses, goggles and face shields should be removed carefully to prevent self-contamination.

If re-used, eye protection should be cleaned in a manner that will not lead to contamination. Safety glasses, goggles, or face shields should be cleaned between uses according to the manufacturer's recommendations using a minimum of a low level disinfectant.

To prevent self-contamination, health care workers should not touch their eyes during care of a resident with ILI.

3.2.6 Gloves

Staff and volunteers should wear gloves when they are likely to have contact with body fluids or touch contaminated surfaces.

Gloves are an additional protective measure, and are not a substitute for proper hand hygiene.

Gloves should be put on before entering and removed prior to leaving the resident's room or dedicated bed space.

Gloves should fit the wearer to prevent cross contamination through contact.

Gloves should be changed between procedures on the same resident (e.g., between open suctioning of a tracheostomy and remainder of care).

Hands must be washed immediately after removing gloves.

When a gown is worn, the cuff of the gloves must cover the cuffs of the gown.

Single-use gloves should not be reused or washed.

Gloves should be changed whenever a tear or leak is suspected.

3.2.7 Gowning

Long-sleeved gowns should be worn during procedures and resident care where clothing might be contaminated.

Gowns should be removed before leaving the resident's room or dedicated space.

3.2.8 Environmental Cleaning

The LTCH will use the same routine infection control and cleaning procedures during an influenza pandemic as they do for seasonal influenza.

The use of commercial, pre-packaged disinfectant wipes that are easily accessible to all staff allows efficient cleaning of equipment and surfaces. All LTCHs should follow the Public Health Agency of Canada *Infection Control Guidelines on Hand Washing, Cleaning, Disinfection and Sterilization in Health Care* (see <http://www.phac-aspc.gc.ca/publicat/ccdr->

Recommended Process for Removing Personal Protective Equipment (PPE)

After the health care provider has completed patient care and is >one metre distance from the patient:

- Remove gloves and discard using a glove-to-glove/skin-to-skin technique.
- Remove gown (discard in linen hamper in a manner that minimizes air disturbance).
- Perform hand hygiene.
- Remove eye protection and discard or place in clear plastic bag and send for decontamination as appropriate.
- Remove mask and discard.
- Perform hand hygiene.

This is a minimum procedure. If staff believe their hands have become contaminated during any stage of PPE removal, they should perform hand hygiene before proceeding further.

[rmtc/98pdf/cdr24s8e.pdf](http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/98pdf/cdr24s8e.pdf)). The guidelines include the appropriate cleaning agents to use and contact time.

Procedures should be established for assigning responsibility and accountability for routine cleaning of all environmental surfaces including furniture (e.g. bed rails, overbed table, telephone) and non-critical resident care items (e.g. call bell).

Disinfection methods should be reviewed.

Environmental surfaces should be cleaned frequently using hospital approved detergent-disinfectant.

Resident care items should be cleaned and disinfected between each resident use.

Components of an effective cleaning process include a sufficient quantity of detergent-disinfectant in the correct concentration applied with a clean cloth, and a contact time that complies with the manufacturer's label and workplace safety requirements.

All horizontal and frequently touched surfaces should be cleaned daily and more often when soiled.

Routine practices should be applied in the handling of soiled linen.

Routine practices should be applied to handling clinical waste. Double bagging of waste is not required. Disposable dishes and cutlery are not required.

3.2.9 Cleaning Resident Care Equipment

Remind staff, students and volunteers of the recommendations for cleaning, disinfecting and sterilizing patient care equipment in the Public Health Agency of Canada *Infection Control Guidelines on Hand Washing, Cleaning, Disinfection and Sterilization in Health Care* (see <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/98pdf/cdr24s8e.pdf>).

Disposable equipment should be used whenever proper cleaning of the equipment can no longer be done.

Soiled patient care equipment should be handled in a manner that prevents exposure of skin and mucous membranes and contamination of clothing or the environment.

Equipment should be cleaned and disinfected prior to use and between uses.

3.3 Notify Appropriate Individuals

The LTCH will notify individuals who work in or with the home, including:

- the medical consultant or medical director
- the director of care or director of nursing
- the administrator
- the operator or board of directors
- the chair of the infection control committee
- the infection control professional
- the provider of the home's laboratory services
- the employee health nurse
- maintenance supervisor
- the director of food services/food services supervisor
- the director of housekeeping/environmental services supervisor
- patient representatives
- pharmacist

- staff members
- community volunteers (family members/ caregivers)
- registered nurses in the extended class (nurse practitioners)
- others as appropriate.

3.4 Hold an Initial Outbreak Management Team Meeting

At the initial meeting, the OMT should:

- confirm an outbreak exists and ensure that all members of the team have a common understanding of the situation
- adopt a working case definition or criteria that will be used to identify residents or staff with influenza caused by the pandemic strain (Note: The case definition developed for residents may be different from that developed for staff. Residents who meet this case definition will be considered a case regardless of the results of laboratory testing unless another diagnosis is confirmed.)
- review the control measures necessary to prevent the virus from spreading (see section 4) and confirm the ICP or designate who is responsible for ensuring that agreed upon control measures are in place and enforced, and for modifying control measures depending on the epidemiology of the pandemic strain
- identify/confirm the appropriate signs/information to be posted in the home, and the appropriate locations
- institute exclusion policies and the staffing contingency plan
- enforce proper use of PPE
- report the outbreak to appropriate people/institutions outside the home, such as:
 - residents' attending physicians
 - other health care providers (e.g. physiotherapists)
 - families of ill residents
 - families of all residents in the home
 - compliance advisor from the MOHLTC
 - staffing agencies
 - coroner's office
 - funeral directors
- implement the LTCH's influenza pandemic communication plan (e.g., distribute internal communications for resident, family and staff groups; determine if education sessions are required for staff members and who will conduct them; confirm how and when daily communications will take place between the home and the local public health unit; ensure that contact telephone numbers are available 24 hours a day, seven days a week for both the local public health unit and home)
- clarify the role of the local public health unit, and the availability of public health services, including laboratory testing (**Note: the level of public health assistance will depend on the extent of pandemic activity in the community.**)
- decide how frequently the OMT will meet and set next meeting.

3.5 Monitor the Outbreak/Conduct Ongoing Surveillance

Outbreak monitoring includes ongoing surveillance to identify new cases and update the status of ill residents and staff. During a pandemic, LTCHs will continue to report cases of ILI and deaths to the local public health unit. The ICP or designate will update the pandemic outbreak reporting forms and submit them weekly to the local public health unit by fax.

The local public health unit will use the information to:

- track the spread and impact of the pandemic
- monitor ongoing transmission and the effectiveness of infection prevention and control measures
- recommend changes in the home's infection prevention and control practices, if required.

Depending on the course of the pandemic, some measures may be added or lifted and additional testing may be required (e.g., testing for antiviral resistance).

Note: Once the pandemic strain is suspected/identified in the LTCH, staff will treat all subsequent cases of ILI with similar symptoms as influenza unless that diagnosis is ruled out.

The LTCH will also continue to report new infections in staff to occupational health services and work with staff and OHS to ensure that appropriate precautions are being taken in the workplace to protect workers and patients.

3.5.1 Resident Surveillance

LTCHs will collect the following surveillance information on residents:

- new cases with all appropriate information
- residents who have recovered
- status of ill residents including notation of issues such as worsening symptoms, clinical and/or x-ray diagnosis of pneumonia
- number of residents receiving antiviral prophylaxis
- number of residents receiving antiviral prophylaxis who go on to develop ILI (i.e., signs of antiviral resistance)
- adverse reaction to any prescribed antiviral medication or vaccine, or discontinuation of antiviral prophylactic medication
- transfers to acute care hospitals
- deaths.

3.5.2 Staff Surveillance

LTCHs will collect the following surveillance information on staff:

- new staff cases including all appropriate information
- status of ill staff
- staff who have recovered and their return to work date
- staff who still have symptoms but are considered fit to work and are working in the home

Monitoring and Ongoing Surveillance

Use pandemic outbreak reporting forms provided by the local public health unit (under development) to collect surveillance data about residents with ILI.

Confirm the population at risk in the home, including:

- the total number of residents and the number of all staff, including casual workers and non-patient care staff, employed at the home
- for large homes, it may be useful to keep a separate line listing for each unit affected by the outbreak and for staff with ILI.

Continue to collect resident and staff surveillance information throughout the pandemic, staff resources permitting (see Appendix 5 for sample line listing form).

- with restrictions (e.g., caring only for residents with ILI) and using appropriate PPE
- number of staff receiving antiviral prophylaxis and number who go on to develop ILI (i.e., signs of antiviral resistance)
- adverse reaction to any prescribed antiviral medication or vaccine, or discontinuation of antiviral prophylactic medication.

3.6 Implement Control Measures for Residents

During an influenza pandemic, LTCHs will have to make decisions about residents' care and how they will manage or contain residents with influenza within the home. Should residents be isolated in their rooms or units? Should they be moved to an infirmary within the home? Should special steps be taken to protect medically fragile residents?

These decisions will depend on the structure of the home (i.e., does it have the capacity to establish an infirmary?), the severity of the pandemic strain, and the nature of the home's population. At a minimum, LTCHs should consider identifying higher risk residents and making arrangements to separate them from residents with influenza.

3.6.1 Restrict Ill Residents to Their Room During the Outbreak

Residents with ILI should be restricted to their rooms as long as it does not cause the resident undue stress or agitation and can be done without applying restraints.

3.6.2 Cohort Residents/Restrict Residents to Their Unit During the Outbreak

Whenever possible, residents with influenza should be in single rooms or co-horted in one unit. In those units, steps should be taken to avoid crowding and to maintain at least one metre (three feet) separation between residents. If residents with influenza are cohorted in one unit, they should avoid contact with residents in the remainder of the home.

3.6.3 Admissions, Re-admissions and Discharges

The LTCH should collaborate with acute care hospitals, the local public health unit and CCACs to make decisions about admissions and re-admissions during a pandemic. Decisions will be affected by resident needs, staffing levels at health care facilities in the community, as well as by the course of the pandemic (i.e., if LTCHs do not have enough staff to provide adequate care, they may not be able to take new admissions). The protocol may vary depending on the regions/areas affected by the pandemic.

If there is pandemic activity in the community but not in the home, LTCHs will want to take extra precautions not to admit someone with ILI into the home. All new admissions should be screened using the FRI protocol (see Appendix 4). If homes do not have enough staff to provide adequate care, they may not be able to take new admissions.

When LTCHs have active cases of influenza in the home or unit, admissions and re-admissions are generally not permitted, but this protocol may change depending on community needs.

Factors to guide decisions about admissions include:

- the status of the pandemic
- the resident's health needs and the advice of the resident's attending physician
- staffing levels at the LTCH
- access to antivirals

- the home's ability to provide appropriate accommodation and care services that require particular expertise (e.g., peritoneal dialysis, tube feeding)
- the patient/resident or their substitute decision-maker has given informed consent.

If there is local pandemic activity, LTCHs may consider discharging residents to family members if they can be cared for appropriately in a family member's home.

3.6.4 Medical Appointments

Non-urgent appointments should be rescheduled.

3.6.5 Transfers to Hospital

Transfers are likely to be restricted during a pandemic, and transfer procedures may change. As part of community planning for a pandemic, LTCHs should work with acute care hospitals and the Provincial Transfer Authorization Centre (PTAC) to develop protocols and criteria for transferring residents to hospital (e.g., residents requiring life sustaining services, such as hemodialysis). LTCHs will use the following procedures unless informed otherwise.

- When any resident is to be transferred to the hospital from a home with pandemic activity, the home will advise the receiving hospital and PTAC.
- The hospital ICP must be provided with the details of the case to ensure control measures are in place when the resident arrives at the hospital.
- The outbreak transfer notification attached in Appendix 5 can be used to provide the required information.

Please note that all transfers from one healthcare facility to another must follow a transfer authorization process at all times. Fax PTAC at 416-397-9061 for a transfer request, or use the web-based application if available. If approved, an authorization number will be issued immediately and faxed or issued on-line to the home.

3.6.6 Transfer to Another Long-Term Care Home

Resident transfers (from anywhere in the home) to another LTCH are not normally recommended during an influenza outbreak. However, during a pandemic, this policy may change in order to ensure residents receive appropriate care. The Medical Officer of Health or designate should be consulted regarding transfers to other LTCHs. The PTAC process described above should be used for all transfers.

3.6.7 Communal Meetings

When there is pandemic activity in the LTCH, all residents should be restricted to their units as much as possible. Previously scheduled events (e.g., celebrations, outings, group activities) should be postponed. The OMT should discuss restricting activities and revisit the issue as the outbreak progresses. Local public health units will provide advice on the extent to which organizations should limit larger gatherings of people.

3.7 Control and Support Measures for Staff and Volunteers

3.7.1 Deploying Staff

Individual LTCHs will continue to be accountable for their own staffing. They will deploy staff as well as other temporary staff and workers as required to maintain adequate levels of care, making use of transferable skills and delegated acts as required, based on their pandemic plans.

3.7.2 Supporting Staff

LTCHs should work with unions to identify supports that will help staff provide care during a pandemic such as:

- assistance with transportation
- accommodation and meals
- access to counselling and psychosocial support to help staff cope with job-related stress or with anxiety about the pandemic
- flexible scheduling that gives staff time to fulfill family responsibilities with family-related needs
- assistance with babysitting for children (i.e., if schools are closed or staff are working extra shifts), caring for elderly family members, and caring for pets.

3.7.3 Reporting Influenza in Staff

Staff and volunteers who develop ILI should report their illness to their supervisor or Employee Health who will report to the home's infection control practitioner.

3.7.4 Excluding Staff, Students, and Volunteers from the LTCH

Ideally, staff, students, and volunteers with ILI should be excluded from work until they are fully recovered. The length of time that ill workers should be excluded will be determined by public health authorities based on the epidemiology of the pandemic strain.

However, if LTCHs do not have enough people to provide safe care, they may allow staff, students and volunteers to work before they are fully recovered. If this is necessary, staff, students and volunteers with ILI should be restricted to non-direct care or to working with residents with symptoms of ILI and should use appropriate PPE. They should NOT be deployed to care for high risk, medically fragile patients.

During a seasonal influenza outbreak, non-immunized staff who are not taking antivirals are excluded from work. During an influenza pandemic, this measure may not apply until a vaccine has been developed or until there is an adequate supply of antivirals available. If there is an adequate supply of antivirals, homes may restrict staff who are not taking antivirals and establish some mechanism to require proof that staff are taking prescribed antivirals. Guidelines related to antiviral use will be finalized and communicated at the beginning of the pandemic, based on the epidemiology of the strain of influenza. If issues arise regarding compliance with work exclusions, they should be discussed with the OMT.

3.7.5 Cohort Staff

To protect staff, students and volunteers, LTCHs should minimize their movement between

floors/resident home areas, especially if some units are unaffected. For example, staff could be restricted to working on a particular unit or caring for a particular group of residents. The ability of LTCHs to cohort staff will depend on the number of staff available to work. These measures may not be required if staff are taking antivirals and using appropriate infection prevention and control practices.

3.7.6 Policies for Managing Staff who Work at Other Facilities

During seasonal influenza outbreaks, LTCHs may restrict staff movement so as not to transmit the virus from one facility to another. During an influenza pandemic, the virus will be widely circulating in the community and will affect many institutions. Trying to prevent spread from one institution to another by restricting the movement of staff will likely be ineffective. If there are significant staff shortages throughout the health care system, everyone may be needed to work. In this case, there may be few restrictions on staff, students and volunteers working in other facilities. The only exception would be a LTCH that has not had any pandemic activity. That home would likely restrict staff, students and volunteers who have worked at sites where there is pandemic activity – unless they have proof of taking antivirals.

3.8 Control Measures for Visitors and Volunteers (including family)

3.8.1 Notifying Visitors and Volunteers

The LTCH will activate its pandemic/emergency communication plan and activities. Signs will be posted at all entrances indicating the situation (e.g., pandemic activity in the community and/or pandemic activity within the home). Visitors will be advised of the potential risk of either introducing influenza into the home or acquiring influenza within the home, and of the visiting restrictions, if applicable.

In the event of an outbreak, family members of ill residents will be contacted. Where possible, the home will keep a telephone list of frequent visitors who should be contacted and advised of the outbreak.

LTCHs will use other communication systems as appropriate (e.g., web site) to maintain communications with family members and visitors.

3.8.2 Visitor Restrictions

During seasonal influenza outbreaks, visitors are encouraged to postpone visits wherever possible. During a pandemic, this policy may not be practical. LTCHs may need family members to assist with care (see 2.2).

All visitors who choose to visit during an outbreak shall be required to:

- wash hands on arrival, before leaving the resident's room, and before leaving the LTCH
- use PPE as instructed by staff
- visit only one resident and exit the home immediately after the visit – unless they are assisting in providing care for residents.

LTCHs will develop visitation restrictions based on the nature of the pandemic; however, complete closure of visitation is not recommended, as it may cause emotional hardship to both the residents and the relatives. Visiting restrictions should be discussed by the OMT and take into account family/visitor access to antivirals.

Restrictions on Ill Visitors

Under the FRI screening protocol, visitors who are ill are asked not to enter the LTCH until they have recovered. During an influenza pandemic, if there are severe staff shortages, visitors with ILI may be allowed to enter the home and assist in providing care for residents before they are fully recovered. If this is necessary, they will be restricted to assisting with non-direct care or to working with residents with symptoms of ILI and will use appropriate PPE.

3.8.3 Visiting Ill Residents

LTCHs will post notices on the doors of the rooms of ill residents or in other visible locations, advising visitors to check at the nursing station before entering the room. The nursing station will advise visitors about any restrictions and instruct them in the proper use of PPE, if required.

Ill residents should be visited in their room only. Visitors should remain in the ill resident's room and not visit other residents.

3.8.4 Communal and Other Activities

Visits by outside groups (e.g., entertainers, community groups) shall not be permitted. Visits to multiple residents will be restricted, unless the visitor is assisting with care and activities of daily living.

Onsite adult and childcare programs may be reduced or curtailed, based on the capacity of the LTCH to staff them. As long as homes have enough staff, they can continue to provide these programs, unless instructed otherwise by the local public health unit. There should be no interaction between ill residents and program participants. Program participants should be screened for ILI before entering the home.

3.9 Antiviral Distribution and Administration

The Public Health Agency of Canada is establishing a national stockpile with a target of 16 million doses of oseltamivir: enough to treat 1.6 million people (i.e., two doses a day for five days). Ontario is also establishing a provincial stockpile and will be responsible for coordinating distribution of antiviral supplies to public health units during a pandemic. Local public health units will then be responsible for coordinating distribution among local health care organizations. (See OHPIP, Appendix 8, Ontario Emergency Mass Vaccination/Prophylaxis Plan.)

LTCHs are responsible for communicating with the local public health unit about their antiviral needs. Priority groups for antivirals may change depending on the course of the pandemic. LTCHs will review their priority groups based on directives from the local public health unit, and determine the amount of antivirals required.

Objectives of an Antiviral Program

- To maintain an adequate, secure supply of antivirals to meet the need for treatment and prophylaxis
- To store, distribute, allocate and administer antivirals efficiently and appropriately
- To monitor the safety and effectiveness of antivirals as well as any development of resistance to antivirals.

3.9.1 Antiviral Storage, Security and Monitoring

All supplies of antivirals kept on site must be stored appropriately and securely. To reduce security concerns, the home should communicate clearly to staff that it maintains only a small

supply of antivirals on site. LTCHs will also keep records of who has received antivirals (i.e., name of receiver, name of person who administered, signatures) similar to those used for administering narcotics, as well as antiviral uptake, effectiveness and any adverse reactions.

The LTCH will work with the local public health unit to determine the monitoring and adverse reaction information to be gathered and reported on antivirals.

3.9.2 Antiviral Medication for Prevention/Prophylaxis

During an influenza pandemic, available supplies of antiviral medication for prevention will be made available to staff and residents based on the provincially identified priority groups, and will be administered and tracked using established LTCH policies and procedures.

3.9.3 Antiviral Medication for Treatment

To be effective, antiviral treatment must be started within 48 hours of onset of symptoms. The earlier treatment is started, the more effective it is. Treatment decisions are the responsibility of attending physicians, but it may be difficult to reach attending physicians during an influenza pandemic, so LTCHs should have medical directives and consent forms on file that allow them to administer antivirals to residents who are ill with ILI.

3.9.4 Administration of Oseltamivir

Although there are two categories for receipt of antivirals (i.e., people who require antivirals for treatment and people who require them for prevention/prophylaxis), one category does NOT have priority over the other. Antivirals will be administered to both priority groups simultaneously: that is, treatment of ill persons and prophylaxis of residents and staff in LTCHs will occur at the same time.

Antivirals will be supplied to LTCHs as needed, based on available supplies and demand in the community. The antivirals will then be distributed based on approved priority group lists. LTCHs may make arrangements (e.g., a service agreement) with the pharmacy affiliated with the LTCH to assist in dispensing and administering antivirals.

3.9.5 Obtaining Reimbursement for Antivirals from the Drugs Programs Branch

During a pandemic, this will not apply because the MOHLTC will be supplying the antivirals.

3.10 Vaccine Distribution and Administration

3.10.1 Roles and Responsibilities

The federal government is responsible for vaccine procurement and supply. The province is responsible for coordinating vaccine distribution for Ontario. Once a vaccine becomes available, local public health units will be responsible for coordinating immunization programs in their areas.

LTCHs are responsible for maintaining an up-to-date list of staff and residents who should have priority access to influenza vaccine (based on priority groups identified by public health authorities) and identifying their vaccine needs. The local public health unit will inform LTCHs about how vaccine will be distributed and administered.

LTCHs may also be asked to monitor and report to the local public health unit any adverse reactions to vaccine. The LTCH will work with the local public health unit to determine the information to be gathered and reported.

3.10.2 Immunization Strategy

Ontario's Health Plan for an Influenza Pandemic is based on a "pull" strategy that asks people to attend mass vaccination clinics. Because so many residents of LTCHs are medically vulnerable, the LTCHs will use a "push" strategy, working with the local public health unit to administer immunizations in the homes. The local public health unit will be responsible for distributing and tracking vaccine use in order to manage limited supplies and ensure consistency, while the LTCH will be responsible for administering immunizations to staff and residents, based on priority groups. (See OHPIP, Appendix 8, Ontario Emergency Mass Vaccination/Prophylaxis Plan.)

3.10.3 Vaccine Storage and Security

Because vaccine for the pandemic strain will be in short supply when it becomes available, it is unlikely that LTCHs will be storing vaccine. However, if homes do have to store vaccine, they must have the cold chain storage capacity required to meet public health guidelines (i.e., keep the vaccine at a temperature between 2 and 8° C) as well as contingency plans in case of power failure or equipment malfunction.

3.11 Investigate the Outbreak

When the outbreak is declared over (see box), an outbreak investigation file should be established, containing:

- copies of laboratory and other results
- copies of all meeting minutes and other communications
- any other documentation specific to the investigation and management of the outbreak.

The LTCH and the local public health unit will jointly complete the ministry pandemic outbreak form and submit the completed report to the MOHLTC. For seasonal influenza outbreaks, this report is due within three weeks of the outbreak being declared over. Timelines may be adjusted during a pandemic, depending on the availability of human resources to complete reports. Copies of all documents related to the outbreak (e.g., outbreak forms, line listings) are to be kept on file by the ICP at the home.

3.12 Review the Pandemic Outbreak

When the pandemic wave is over, meet with local public health unit staff and other community partners to review the course and management of the outbreak of the pandemic strain in the home and in the community, and identify what was handled well and what could be improved. Submit the report to the infection control committee, with a copy to the LTCH's administrator.

Declaring the Outbreak Over

The length of time from the onset of symptoms of the last case until the outbreak is declared over will be one incubation period plus one period of communicability for the pandemic strain. (Note: This may be longer than the 8-day period used for seasonal influenza.)

Because LTCHs may have sporadic seasonal influenza activity during a pandemic, the OMT may need to differentiate between seasonal and pandemic cases in declaring the end of a pandemic outbreak.

The OMT will determine whether ongoing surveillance is required to:

- maintain general infection prevention and control measures outlined in Step 2
- monitor the status of ill residents, update the line listing and communicate with the public health unit
- monitor any deaths that occur, including whether individuals who die had been a line listed case, and inform the public health unit.

The OMT will notify the local public health unit when the LTCH has gone the recommended length of time without a new case. The local public health unit will be responsible for declaring the outbreak over and for notifying the MOHLTC and other organizations in the community.

Appendix 1: Pandemic Preparedness Checklist

Task/Activity	Yes/No	Action Required
1. Planning		
1.1. Does the LTCH have an influenza/respiratory infection outbreak plan?		
1.2. Is the influenza plan reviewed/updated regularly?		
1.3. Does the LTCH have an influenza pandemic plan or a section in its influenza/respiratory infection outbreak plan that deals with the potential impact of an influenza pandemic?		
1.4. Does the LTCH have an emergency or disaster plan?		
1.5. Has the LTCH developed plans to ensure continuity of services in the event of internal emergencies (e.g., lack of water, hydro, food, natural gas failure) related to a disruption of community services?		
1.6. Are emergency/continuity plans reviewed/updated regularly?		
1.7. Does the LTCH have an evacuation plan?		
1.8. Is the evacuation plan reviewed/updated regularly?		
1.9. Does the LTCH have a collaborative planning relationship with other health care organizations in the community (e.g., local public health unit, emergency medical services, CCAC, acute care hospitals)?		
1.10. Have the planning partners developed criteria to determine where and how people will be cared for in the event of a pandemic?		
2. Chain of Command/Command Centre		
2.1. Does the LTCH have an interdisciplinary pandemic planning committee and/or a pandemic outbreak management team that include representatives from administration?		
2.2. Does the LTCH have a designated Infection Control Professional (ICP) and back up and a designated Occupational Health and Safety representative and back up who are known to staff and available 24/7?		
2.3. Are all staff aware of their roles/responsibilities during a pandemic outbreak?		
2.4. Is there a designated area in the facility that staff can obtain information on /be alerted to a potential influenza pandemic?		
2.5. Is there a chain of command for implementing the pandemic plan? (i.e., if administrator is not available, who is next in command?)		
2.6. Is there a designated assembly point where all personnel report? Does it change if staff are involved in resident care or have		

administrative responsibilities?		
2.7 Does the LTCH have a designated command centre?		
2.8 Have provisions been made (e.g., space, equipment, communications) for extra people who may come to the Command Centre to provide services (e.g., volunteers and outside agencies)?		
3. Resident Needs		
3.1 Does the LTCH have an up-to-date assessment of residents' essential care needs?		
3.2 Has the LTCH identified residents who could be cared for in other settings if necessary?		
3.3 Has the LTCH identified residents at high risk of complications from influenza and identified strategies to reduce their risk?		
3.4 Is information from ongoing resident assessments incorporated into the resident assessment plan?		
3.5 Does the resident assessment plan specify the skills/expertise required to meet the resident's needs?		
4. Essential Services		
4.1 Has the LTCH identified essential services that must be maintained during an pandemic?		
4.2 Has the LTCH identified non-essential services that could be reduced or curtailed?		
4.3 Does the LTCH have a mechanism to contact outside services (e.g., physiotherapy, occupational therapy, dental services) in the event of a pandemic outbreak?		
5. Antivirals and Vaccine		
5.1 Has the LTCH identified priority groups for antiviral treatment and prophylaxis?		
5.2 Has the LTCH identified priority groups for vaccine?		
5.3 Is the enumeration tool for priority access to antivirals and vaccine reviewed/updated yearly?		
5.4 Does the LTCH have adequate capacity to store antivirals?		
5.5 Does the LTCH have access to an initial supply of antivirals?		
6. Supply Chains		
6.1 Has the LTCH identified the supplies required during an influenza pandemic (see Appendix 3 for supplies template)?		

6.2 Does the home have contracts with local suppliers to provide medical equipment?		
6.3 Will these suppliers be able to fulfill contracts during an influenza pandemic? If not, does the LTCH have a back-up source of supply?		
6.4 Does the LTCH have access to an adequate supply of commonly used pharmaceuticals (e.g, Ciprofloxacin, Doxycycline, bronchial dilators)		
6.5 Has the LTCH identified and established relationships with other health care facilities outside the region as a means of accessing possible sources of needed pharmaceuticals, equipment, supplies, and staff?		
6.6 Has the LTCH made arrangements to obtain and transport supplies for life sustaining supplies (e.g., for hemodialysis and peritoneal dialysis)?		
7. Human Resources		
7.1 Has the LTCH identified the skills that will be required during a pandemic?		
7.2 Has the LTCH identified the skills that existing staff – including administrative and non-patient care staff can provide?		
7.3 Does the LTCH have a staffing contingency plan in case 20 to 35% of staff fall ill?		
7.4 Does the LTCH have a policy for addressing work refusal?		
7.5 Has the LTCH identified potential outside sources of human resources (e.g., nursing agencies, other community organizations, volunteers, family members)		
7.6 Has the LTCH developed plans to support staff during a pandemic (e.g., child care, transportation, psychosocial support, meals, accommodation, assistance with pet care)?		
7.7 Has the LTCH developed a plan for cohorting staff?		
8. Communications		
8.1 Has the LTCH established a communication system with the local public health unit and other partners?		
8.2 Does the LTCH have a plan for communicating with staff, residents, volunteers and family members during a pandemic, including the person/s responsible for notifying staff and families?		
8.3 Does the LTCH have alternative methods of internal and external communication if main method of communication is not available?		
8.4 Is there an organized runner, messenger system as back-up for communication system and power failures?		
8.5 Has the LTCH established a designated area for media?		
8.6 Have key personnel been designated to control and take care of the needs of the media?		

8.7 Has the LTCH designated a media spokesperson? Is there a plan for this person to coordinate messages with the local public health unit?		
8.8 Has the LTCH developed procedures for handling requests for information from the media? Are these provisions consistent with the Public Health Information and Privacy Act (PHIPA)?		
9. Security		
9.1 Does the LTCH have the ability to lock down so entry and exit to all parts of the facility can be controlled? Has this process been tested?		
9.2 Have arrangements been made to meet and escort responding emergency service personnel?		
9.3 Have steps been taken to minimize and control points of access in the building and areas without utilization of lock down procedures?		
9.4 Does the LTCH have the ability to communicate with individuals immediately outside the Home in the event access is restricted?		
9.5 Does the LTCH security plan recognize the extent of the security problems for the individual facility? These considerations include the uniqueness of the physical plant, geographic location, entrances.		
9.6 If outside staff is required to meet the residents needs during a pandemic, are their credentials verified?		
10. Traffic Flow and Control		
10.1 Have provisions been made for internal traffic that allow for movement of residents through corridors and staff movement throughout their areas? (e.g., designated unit/ home area staff room instead of communal room)		
10.2 Does the LTCH have plans to restrict access in affected areas of the home?		
10.3 Will elevators be staffed and controlled?		
10.4 Is there a designated entrance and exit for both vehicles and people?		
10.5 Has the LTCH made provisions for deliveries (i.e. supplies and equipment)?		
10.6 Is there authorized vehicle parking?		
10.7 Has the LTCH made arrangements for signs to direct authorized personnel and visitors to proper entrances?		
11. Surveillance		
11.1 Does the LTCH promote annual immunization of staff and residents?		

11.2 Does the LTCH routinely assess residents for febrile respiratory infection (FRI) and/or influenza-like illness (ILI) when applicable?		
11.3 Does the LTCH encourage staff to report FRI or ILI symptoms?		
11.4 Does the LTCH currently screen visitors for FRI or ILI?		
11.5 Does a process exist to notify infection control designate within 24 hours when an outbreak is suspected?		
11.6 If so, is this process clearly communicated and readily available to all key staff in the organization?		
12. Education and Training		
12.1 Does the pandemic plan specify who is responsible for the training program?		
12.2 Does the plan include methods for ramp up and quick training for new and altered roles (e.g., have policies and procedures been made, have job action sheets been developed)?		
12.3 Does the LTCH have ongoing, mandatory pandemic training programs?		
12.4 Does the LTCH provide pandemic education material at staff orientation to raise staff awareness?		
12.5 Does the program provide ongoing pandemic education to keep staff informed and procedures/practices up to date?		
12.6 Does the hospital/healthcare facility routinely provide training on the proper donning and removal of personal protective equipment?		
13. Visitors		
13.1 Does the plan include a mechanism to deal with anticipated increases in visitors seeking to gain entrance?		
13.2 Has the LTCH made provisions to handle medical and emotional situations resulting from the anxiety and shock of the pandemic situations?		
13.3 Have personnel been designated to control and take care of issues that arise due to visitors?		
13.4 Does the facility have a plan to reduce the risk of visitors entering the facility during a pandemic (e.g., security, signage, restricted access)?		
14. Issues Related to High Mortality		
14.1 Does the LTCH have a system for the safe-keeping of personal items removed from residents who have died?		
14.2 What is the mortuary capacity of the facility? Is offsite surge morgue capacity available (e.g., assess community capacity with local funeral homes)?		

15. Relocation of Residents and Staff		
15.1 Has the LTCH made plans to relocate residents and staff to an immediate area of safe refuge within the LTCH in the event the area must be evacuated (i.e., to facilitate the isolation of residents with ILI)?		
15.2 Has the LTCH made arrangements with other LTCHs and other services to relocate residents if the LTCH is unable to meet residents' needs (e.g., transfers between hospitals and Long-Term Care Homes, local LTCH partnering to support each other by delegating certain resident care activities to one organization while the other focuses on the care of ILI/FI residents)?		
15.3 Has the LTCH identified temporary locations where residents and staff could be housed in the event of an evacuation (e.g., a power failure)?		
15.4 Does the LTCH have a plan for the transportation required to move people to a temporary location?		

Appendix 2: Antivirals and Vaccine

This appendix includes the following information/documents:

1. A guide to using the enumeration tools
2. Working definitions for priority access to antivirals
3. Enumeration tools for use in Long-Term Care Homes
4. Pandemic Influenza: Algorithm for Antiviral Medication

Public Health Division

October 2005

How to use the Enumeration Tool

The Provincial Enumeration tool was developed to assist with pandemic planning at the local level for Health Units, health care facilities and essential services/critical infrastructure. During the first wave of a pandemic (expected to last at least 6 weeks), antiviral medications will likely be used for prevention (prophylaxis)/ early treatment as a vaccine will probably not yet be available. It is expected that there will not be enough antiviral medication available to prophylax everyone.

Purpose of the enumeration tool:

- 1) To assist the province, health units and local organizations in determining how many people are in the groups eligible for prophylaxis
- 2) To plan for the distribution/administration of prophylactic antiviral medication/vaccine in the event of a pandemic.

MOHLTC Priority Definition Table- For Allocating Vaccines and Antivirals (Enumeration Process)

This table is to be used to assist you in identifying the priority groups for prophylaxis and the identification of the roles that will be essential during the pandemic. **Please note: this table is not inclusive of all professionals that may be involved in the pandemic response.**

Current Staffing

This table requires you to list all positions (both staff and management) in your organization. For example if you employ nurses, nurse managers, physicians, personal support workers, dispatchers, kitchen staff, etc., list these under the heading "Position" and then indicate the number of staff in each position. These positions then need to be broken down further to identify how many people are full-time, part-time, casual or working on a contract (i.e. temporary staff for a fixed duration of time). Please do not include workers that are contracted out by your organization (i.e. nurses who work for agencies). The total number of staff in each column should be based on the number of staff persons, not the compliment of FTEs. **Please note: this should reflect your current staffing, not your projected need during a pandemic.**

Essential Staffing

Using your Current Staffing table, identify those roles deemed essential to your organization. Please also indicate the minimum number of staff in each essential position required to keep your organization operating during a pandemic. This process is to fully optimize limited supplies/resources.

The attached tables are examples to assist you. For any further questions, please contact your local health unit.

Ministry of Health and Long-Term Care Priority Definition Table – For Allocating Vaccines and Antivirals (Enumeration Process)				
Group Number	Priority Groups	Applicable Categories	Working Definitions	Examples
Group 1	Prophylaxis of front-line health care providers and key health decision makers	a) Front-line Health Care Provider	Persons who provide or assist in the provision of direct health care (within 1 meter) to potential or known influenza cases with or without personal protective equipment.	doctors/nurses/NPs/receptionists (in hospitals, CHCs, walk-in clinics, LTCHs and family practice settings), home care therapists, ambulance attendants/paramedics/firefighters performing paramedic functions, vaccinators, public health staff anticipating patient contact (clinic staff), laboratory workers, x-ray techs, respiratory therapists, physiotherapists, occupational therapists, porters, dedicated housekeeping, HCAs/PSWs (in hospitals, LTCHs and community settings), CCAC case workers in hospital settings.
		b) Key Health Decision Maker	Persons whose decision making authority is necessary for implementing and maintaining the health sector response to pandemic influenza.	local MOH, AMOHs and other senior health administrators.
Group 2	Prophylaxis of remaining health care providers	a) Essential Health Care Provider	Persons who are trained to provide direct, essential (non-elective) health care to patients for diagnostic, and/or treatment purposes in a hospital, medical office or homecare setting including provision of essential supportive care in a chronic care facility.	doctors/nurses/ NPs/receptionists (in hospitals, CHCs, walk-in clinics, LTCHs, family practice settings, and workplaces), home care therapists, laboratory workers, x-ray techs, respiratory therapists, physiotherapists, occupational therapists, porters, HCAs/PSWs, CCAC case workers.
		b) Public Health Responder	Persons who are essential to the implementation and maintenance of the public health response to pandemic influenza.	public health unit staff and managers, clinic admin staff, security, vaccine transporters.
		c) Essential Health Support Services	Persons who (at a minimum) are essential for maintaining baseline function of a health care facility, assisting the frontline health care providers or assisting key health decision makers.	dispatchers (911 and police), managers, housekeeping staff, kitchen staff, pharmacy staff (in hospital), facility administration, support clerks, shipping & receiving, hospital/LTCH directors, building maintenance, environmental clean up officers, laboratory techs.
Group 3	Prophylaxis of emergency/ essential service providers	a) Pandemic Societal Responder	Persons who are trained or primarily involved in the provision of an essential service which if not sustained at a minimal level would threaten public health, safety or security.	i) fire fighters, police officers "on the street", provincial correctional service officers, fire chiefs, police chiefs, ii) public works and maintenance labourers, traffic controllers, telecommunications, public transport, iii) religious leaders, embalmers, funeral directors.
		b) Key Societal Decision Maker	Persons whose decision making authority will be necessary at the time of the pandemic to minimize societal disruption.	judges, mayors, municipal councillors, MPPs.

NB: Priority groups could change based on the epidemiology of the pandemic influenza virus outbreak.

Current Staffing

1. Please identify all positions (staff and management) in your organization and indicate the number of people in each position (PFT, PPT and casual). Please do not include any contracted positions or services.

Position	Number of Staff			
	Full-time	Part-time	Casual	Contract
Registered Nurse (RN)	5	4	3	0
Registered Practical Nurse (RPN)	10	10	5	0
Housekeeping/ Laundry	7	10	3	0
Health Care Aide/ Personal Support Worker	20	20	10	0
Dietary	6	12	4	0
Plant Maintenance	3	0	0	0
Management/ Administration	2	2	0	0
Activation	4	7	3	
Totals:	57	65	28	0

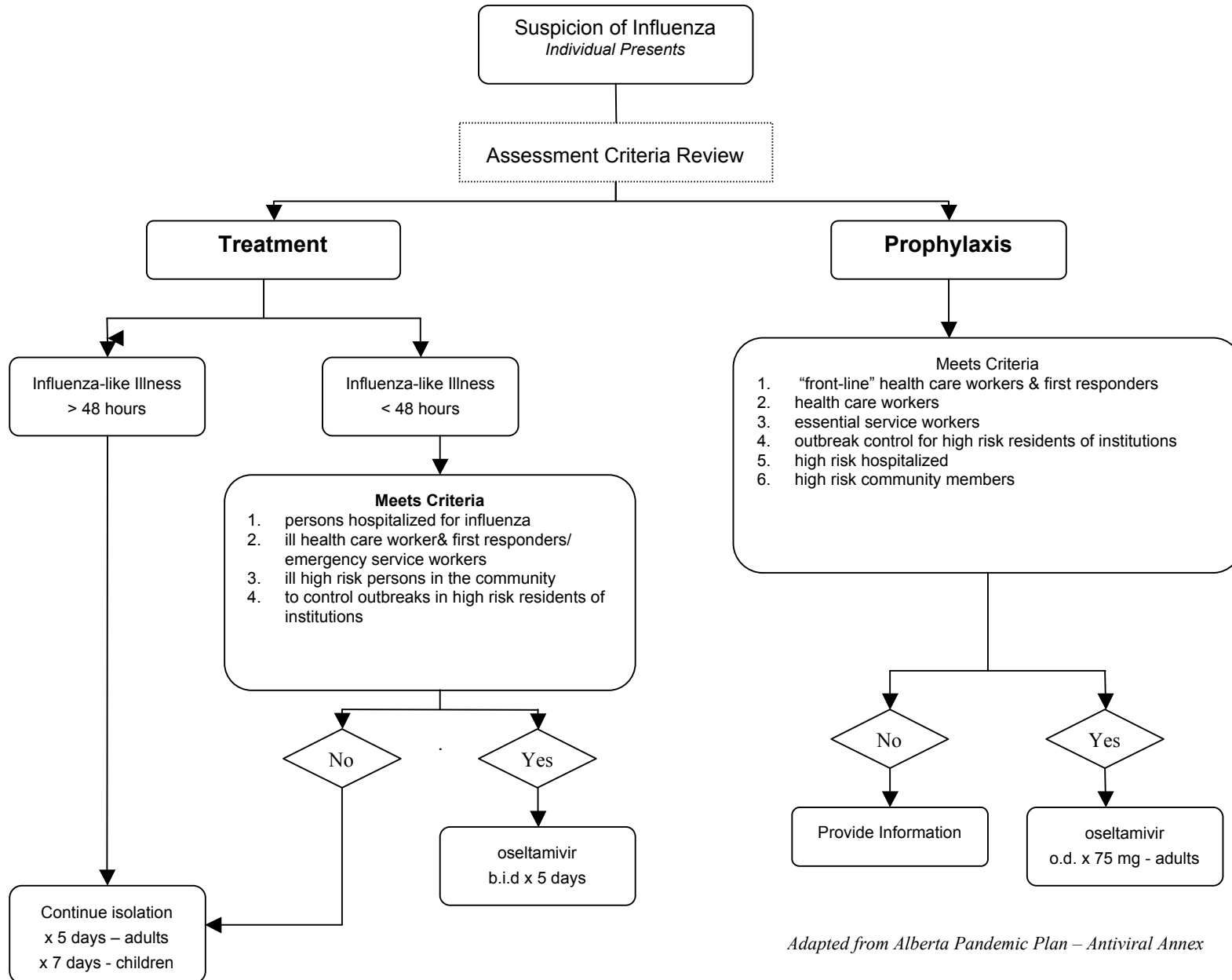
NB: The totals should be based on the number of staff persons (not compliment of FTEs, etc.)

Essential Staffing

2. Identify the **essential positions** in your organization and the **minimum number of staff** required to keep your organization operating during an outbreak. Remember, the first wave of the pandemic could last for 6 weeks or longer.

		Priority Groups as identified in Ministry of Health and Long-Term Care Table						
		"front-line" health care workers and key health decision makers		remaining health care workers			emergency/essential service workers	
Essential Positions	Minimum Number of staff Required in this position	1a) Front-line Health Care Provider	1b) Key Health Decision Maker	2a) Essential Health Care Provider	2b) Public Health Responder	2c) Essential Health Support Services	3a) Pandemic Societal Responder	3b) Key Societal Decision Makers
<i>e.g. RN</i>	4	3	-	1	-	-	-	-
Registered Nurse	9	9		3		0		
Registered Practical Nurse	20	20		5		0		
Housekeeping/ Laundry	13					18		
Health Care Aide/ Personal Support Worker	45	25		25		0		
Dietary	12	0		0		20		
Plant Maintenance	1	0		0		2		
Management/ Administration	2	2		0		2		
Activation	9	6		4		0		
Total:	111	62		37		42		

Pandemic Influenza: Algorithm for Antiviral Medication



Adapted from Alberta Pandemic Plan – Antiviral Annex

Appendix 3: MOHLTC Supplies and Equipment Template: Care in the Home

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

Supplies and Equipment		
Category	Item	#
Hand Hygiene	Liquid Soap	
	Alcohol hand rinse	
	Paper towels	
Personal Protective Equipment	Surgical/ Procedure Masks	
	Paper gowns (small, medium, large, XL, XXL)	
	Latex Exam Gloves (small, medium, large, XL, XXL)	
	Non-latex Gloves (S,M,L,XL)	
	Safety Glasses	
Temperature & BP monitoring supplies	Thermometers (disposable covers)	
	Stethoscopes	
	Blood Pressure Cuffs (Child, Adult, Large Adult sizes)	
Disinfectants	Disinfecting Wipes	
	Surface cleaner and disinfectant	
Cleaning	Garbage bags - clear 20x20 for individual stations	
	Garbage bags	
	Autoclave and other specialized waste disposal bags	
	One-use tissues	
Respiratory Care	Oxygen tubing	
	Oxygen masks -- high concentration masks (non-rebreathers)	
	Nasal prongs/cannula	
	Oxygen masks -- low oxygen concentration (Simple O2 masks, Venturi masks)	
	Oxymeters and probes	
	Portable oxygen tanks with regulators	
	Ventilator supplies	
Suction	Disposable tips, catheters, tubing, canisters	
	Disposable manual resuscitators (BVM) & filters (various sizes)	
	Inline suction catheters	
	Portable suction	
Ice Packs	Cold Pack sodium or ammonium nitrate	
	Gel pack soft cold pack	
Paper products	Paper square absorbent table cover	
Cots or mats		
IV Products	Solutions	
	Tubing	
Deceased body management	Body bags	

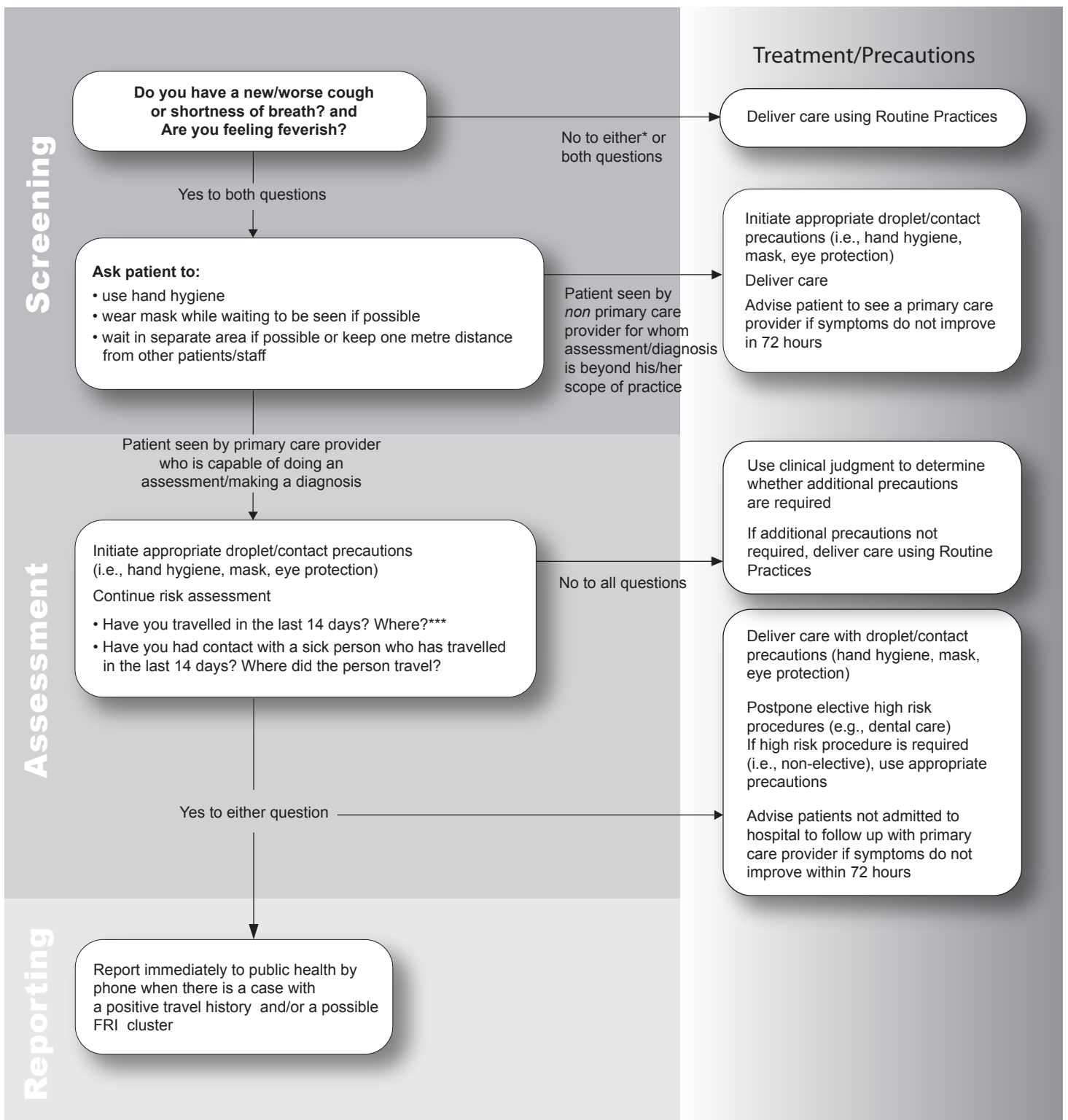
Excerpted from: Ontario Health Plan for an Influenza Pandemic (OHP/IP) June 2005

Appendix 4: FRI Case Finding/Surveillance Protocol

The following case finding/surveillance protocol was developed by the Provincial Infectious Diseases Advisory Committee (PIDAC) and is in use in all health care settings in Ontario to identify cases of febrile respiratory illness, including influenza-like illness.

For more information, see: *Preventing Febrile Respiratory Illnesses: Protecting Patients and Staff. Best Practices in Surveillance and Infection Prevention and Control for Febrile Respiratory Illness (FRI) for All Ontario Health Care Settings*, Provincial Infectious Diseases Advisory Committee (PIDAC), Ontario Ministry of Health and Long-Term Care, 2005.

Case Finding/Surveillance Protocol for Febrile Respiratory Illness



* NOTE: Elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection so the presence of new onset cough/shortness of breath may be enough to trigger further precautions.

** The time frame for travel risk has been changed to 14 days (two weeks), which is consistent with recommendations from the Public Health Agency of Canada. (see: http://www.phac-aspc.gc.ca/sars-sras/pdf/sars-icg-nonoutbreak_e.pdf).

*** For a current list of countries with health alerts, see: <http://www.phac-aspc.gc.ca/tmp-pmv/index.html>

Appendix 5: Forms

This appendix includes:

1. Sample Line Listing Form
2. Outbreak Transfer Notification Form

Outbreak Transfer Notification Form

Sample only

Please be advised that _____ is being transferred from a facility
Name of Resident

where there is a **potential** OR **confirmed** influenza outbreak. Please ensure that appropriate isolation precautions are taken upon receipt of this resident.

At the time of transfer, this resident was **confirmed** OR **suspected** OR **appears free** of influenza.

Resident is on antiviral medication _____ starting on
_____. Dose of the medication _____

Resident's vaccination status is: pneumococcal yes _____ no _____
influenza yes _____ no _____

For further information, contact _____, Infection Control Professional
Name of Infection Control Practitioner

at _____ at _____ - _____
Name of Home Phone Number