19. Long-Term Care Homes

> Influenza almost always selects the weakest in society to kill, the very young and the very old. … Pneumonia was even known as "the old man's friend" for killing particularly the elderly, and doing so in a relatively painless and peaceful fashion that even allowed time to say good-bye.
>
> The Great Influenza, J.M. Barry

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, developed a *Guide to Influenza Pandemic Preparedness and Response In Long-Term Care Homes*. This chapter is excerpted from that document.

19.1 Objective

- To help long-term care homes prepare for a pandemic.
- To reduce the spread of influenza within long-term care homes.

19.2 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 in long-term care homes, which should be adapted to reflect the potential severity of an influenza pandemic.

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 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.

Review and Update Emergency Plans

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

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.

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

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, and notifies committee members of any changes. Records and distributes minutes of meetings.**

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

- residents who are likely to require acute care
- residents at highest risk of complications from influenza as well as 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.

Identify Services that must be Maintained and Services that Could Be Curtailed

During a pandemic, LTCHs will likely be short staffed, and will have to focus on delivering key 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, meal programs, community bathing program, clinics, therapy, appointments and recreational activities
- outside services scheduled to come in (e.g., occupational therapy, physiotherapy, dental services) that are critical and those that can be postponed.

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 by 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 vaccines, 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 Chapter 9A: Ontario Emergency Mass Vaccination/Prophylaxis Plan.)

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 Chapter 10 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).

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 Chapter 8). As part of their planning, LTCHs should identify:

- the skills required to meet residents' needs 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 (i.e., the bargaining agent) in pandemic planning to ensure that their plans include appropriate practice, communication and education.

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, and 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.

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.

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 Chapter 14)
- 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 critical 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.

19.3 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.

Residents

Residents should receive an 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.

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 (1)* 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"(2). 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 prophylaxis should be excluded from providing direct patient care. 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.

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.

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.

19.4 Surveillance

Surveillance is a key 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.

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.

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 weekends and during holiday periods.

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

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 provides 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.

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.

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.

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.

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.

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.

19.5 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.

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.

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, 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.

19.6 Response Level by Pandemic Activity

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. See Figure 19.1.

19.7 Response Steps

When there is pandemic influenza activity in the home, the LTCH will take the following steps. Note: Steps 1 to 6 occur simultaneously.

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
- 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.

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.**

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 (see Chapter 14).

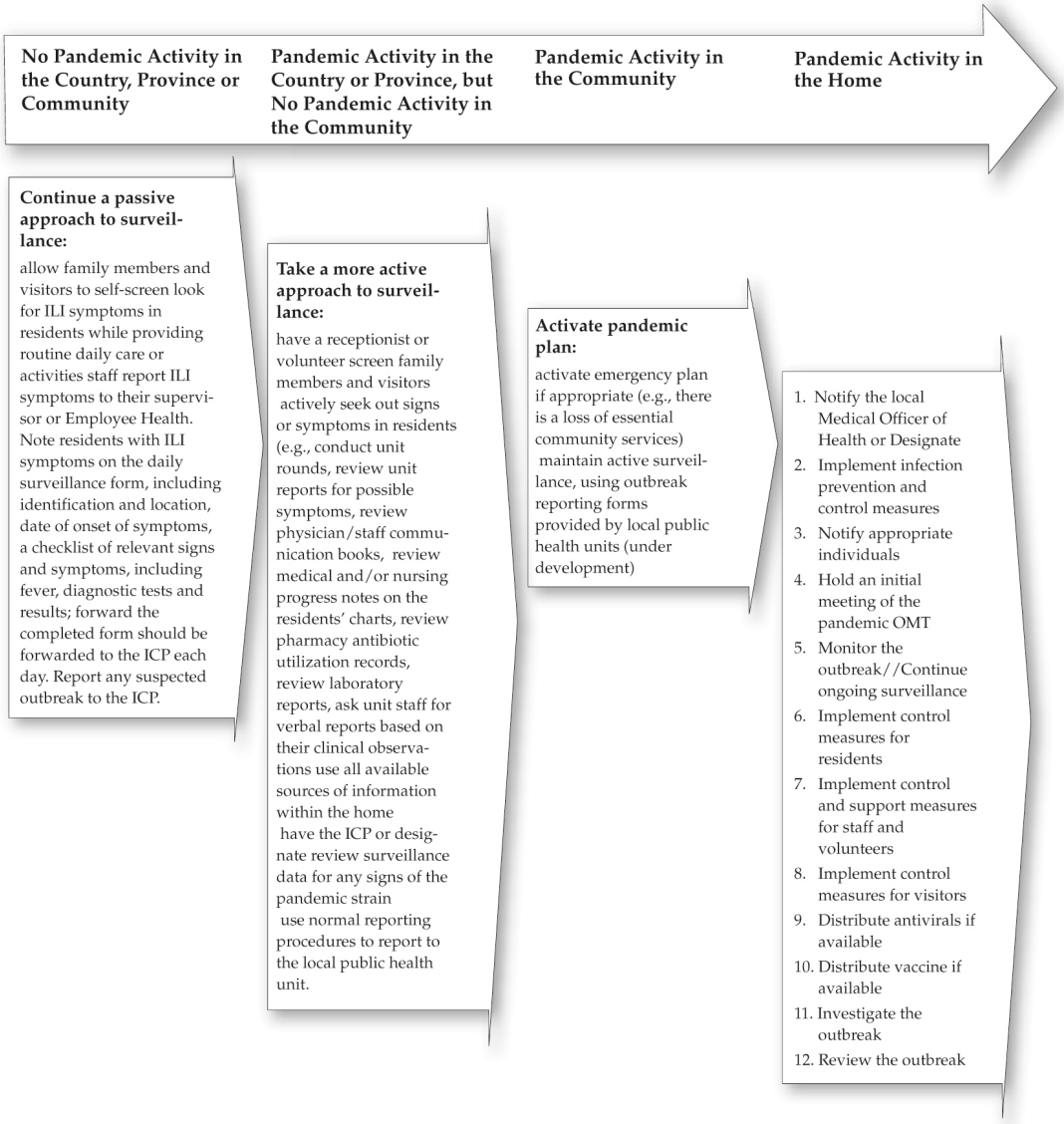
Health units will notify the Public Health Laboratory of the lab testing if required (i.e., complete the laboratory notification sheet, fax it to the laboratory, and follow up with a phone call).

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.

2. Implement Occupational Health/Infection Prevention and Control Measures

See Chapter 7.

Figure 19.1: Response Level by Pandemic Activity in Phase 6



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.

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.

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.

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.

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 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.

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).

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.

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.

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.

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.

Medical Appointments

Non-urgent appointments should be rescheduled.

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.

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.

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.

7. Control and Support Measures for Staff and Volunteers

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.

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.

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.

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.

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.

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.

8. Control Measures for Visitors and Volunteers (including family)

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.

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.

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.

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.

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.

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.

Administration of Antivirals

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

Obtaining Reimbursement for Antivirals from the Drugs Programs Branch

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

10. Vaccine Distribution and Administration

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. 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.

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 (see Chapter 9A: Ontario Emergency Mass Vaccination/Prophylaxis Plan).

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.

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.

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

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.

infection control committee, with a copy to the LTCH's administrator.

References

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

2. 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.

3. 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.