

# Continuing Care PANDEMIC OPERATIONAL GUIDE (COVID-19)

2020



**Table of Contents:**

1. Background.....	3
2. Preface.....	4
3. Purpose.....	5
4. Population.....	5
5. Roles & Responsibilities.....	5
6. Primary Principles.....	6
7. Location(s).....	7
8. Human Resources Planning.....	7
9. Infection, Prevention & Control.....	8
10. Supplies & Equipment.....	8
11. Legislation.....	8
12. Surveillance.....	9
13. Indicators and Required Reporting.....	9
14. Information Management.....	9
15. Communications.....	10
16. Levels of Activation.....	10
References.....	25
Approvals and Signatures.....	27
Appendix A: Glossary of Terms.....	28
Appendix B: Governance Structure and Working Group Membership.....	34
Appendix C: Incident Management System - Overview.....	35
Appendix D: Reporting Structure Diagram.....	37
Appendix F: Care and Treat in Place Guidelines.....	40
Appendix G: Surge Capacity Guidelines.....	43
Appendix H: Surge Capacity Identification.....	44
Appendix I: Service Level Recommendations – Home Living.....	45
Appendix I: Service Level Recommendations – Supportive Living.....	47
Appendix I: Service Level Recommendations – Long Term Care.....	48
Appendix J: Communicating with Continuing Care Service Providers.....	49
Appendix K: Staffing Levels and Use of Volunteers.....	50
Appendix M: Contingency Planning.....	53
Appendix N: Temporary Discharge to Community During Service Interruption.....	54
Appendix O: Changes to Normal Operating Procedures.....	55
Form 1: Sample Surge Capacity Spreadsheet.....	58
Form 2: Influenza-like Illness (ILI) Services in the Home Encounters – Screening Tool.....	60
Form 3: Point of Care Risk Assessment (Facility Based).....	61
Form 4: Infection Prevention and Control – Sample Tracking Form/Template.....	63
Form 5: Pandemic Contingency Planning.....	64
Form 6: Continuing Care Operators - Level of Activation Algorithm.....	68
Form 7: Level of Activation Checklist - Continuing Care Operators.....	69
Form 8: Pandemic Response IV Hydration for Continuing Care Clients.....	71
Form 9: SAMPLE External Referral Form.....	72
Emergency/Pandemic Response.....	72

## 1. Background

On 30 January 2020, WHO announced that the COVID-19 outbreak was a Public Health Emergency of International Concern. As of 4 March 2020, cases of COVID-19 have been reported in 77 countries. To date, most cases were reported from China with cases in some other countries among individuals with travel history to China. In February 2020, the number of cases in China declined while the number of cases and countries reporting cases increased.

Several countries have demonstrated that COVID-19 transmission from one person to another can be slowed or stopped. These actions have saved lives and have provided the rest of the world with more time to prepare for the arrival of COVID-19: to ready emergency response systems; to increase capacity to detect and care for patients; to ensure hospitals have the space, supplies and necessary personnel; and to develop life-saving medical interventions. Every country should urgently take all necessary measures to slow further spread and to avoid that their health systems become overwhelmed due to seriously ill patients with COVID-19.

The Strategic Preparedness and Response Plan for COVID-19 aims to:

- Slow and stop transmission, prevent outbreaks and delay spread.
- Provide optimized care for all patients, especially the seriously ill.
- Minimize the impact of the epidemic on health systems, social services and economic activity.

All countries should increase their level of preparedness, alert and response to identify, manage and care for new cases of COVID-19. Countries should prepare to respond to different public health scenarios, recognizing that there is no one-size-fits-all approach to managing cases and outbreaks of COVID-19. Each country should assess its risk and rapidly implement the necessary measures at the appropriate scale to reduce both COVID-19 transmission and economic, public and social impacts.

COVID-19 is a new disease that is distinct from other SARS, MERS and influenza. Although coronavirus and influenza infections may present with similar symptoms, the virus responsible for COVID-19 is different with respect to community spread and severity. There is still much to discover about the disease and its impact in different contexts. Preparedness, readiness and response actions will continue to be driven by rapidly accumulating scientific and public health knowledge. The Table describes the preparedness, readiness and response actions for COVID-19 for each transmission scenario. Hyperlinks to existing WHO Technical Guidance are provided.

All technical guidance for WHO can be found here:

<https://www.who.int/emergencies/diseases/novelcoronavirus-2019/technical-guidance>

and

<https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>

**Pandemic Event**

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

According to the World Health Organization <sup>1</sup> there is a high risk for pandemic when there is concurrent global circulation of two or more influenza virus subtypes.

**Pandemic Planning in Alberta**

Pandemic planning at the provincial and regional (Zone) levels has been in place since the late 1990's. In 2009, Alberta Health and Alberta Emergency Management Agency (AEMA) consolidated their plans <sup>2</sup> and the then newly formed Alberta Health Services (AHS) developed a provincial pandemic plan to reflect activities required for the pandemic virus.

Following the H1N1 pandemic, the Minister of Health authorized the Health Quality Council of Alberta (HQCA) to conduct a formal review of the provincial response. In the review <sup>3</sup> the HQCA provided a number of recommendations which formed the basis for future revisions.

**Goal of Pandemic Planning**

The goal of pandemic planning is to provide guidance and direction for issues such as:

- Controlling the spread of disease and reducing illness (morbidity) and death (mortality) by providing access to appropriate prevention measures, care, and treatment
- Mitigating societal disruption in Alberta through ensuring the continuity and recovery of critical services
- Minimizing adverse economic impact
- Supporting an efficient and effective use of resources during response and recovery

**2. Preface**

Influenza pandemics are unpredictable recurring events that can cause high rates of illness and death. Advance planning and preparation is necessary to optimize health care delivery during a large scale, widespread health emergency such as a pandemic <sup>4</sup>. The overall expectation of pandemic preparedness is to decrease the impact of serious illness and overall deaths, while minimizing societal disruption in the event of an influenza pandemic. The next pandemic could emerge anywhere in the world, at any time of year, with little lead-time.

The *Continuing Care Pandemic Operational Guide (The Guide)* is a compilation of plans, tools, and resource materials designed to provide the resources necessary to develop a response plan for a pandemic outbreak. All appendices have been hyperlinked for quick reference and all form examples are print ready. All AHS resources and links will be made available on the Continuing Care Connection (CCC) with author permissions.

This guide is provincial in scope while incorporating zone operational requirements. It was developed to support pandemic preparedness processes that reflect best practice while

supporting consistency across Continuing Care programs. The guide also aligns with the AHS Pandemic Operational Guide <sup>5</sup>. It is intended to be a living document and will be regularly updated as overarching plans are revised.

### 3. Purpose

This guide outlines the strategic provincial pandemic operational information for Continuing Care (see Population). It is designed to support a collective and integrated pandemic response among all Alberta Health Services (AHS) owned, operated, and contracted Continuing Care Service Providers. Several operational terms are used throughout this document, see [Appendix A - Glossary of Terms](#) for definitions. For information on sponsorship, development approval processes and working group membership see [Appendix B - Governance Structure and Working Group Membership](#)

The organizational reporting structure includes linkages to the Zones, the AHS Emergency Coordination Center and the Incident Management System ([Appendix C – Incident Management System - Overview](#)) to manage a system wide response in the event of a pandemic. [Appendix D - Reporting Structure Diagram](#).

If the pandemic response is limited to a single site and/or a single zone, the pandemic response will be managed by the operational zone leadership as identified in the Zone Pandemic Response Plan.

### 4. Population

*The Guide* is for AHS owned, operated and contracted Continuing Care Service Providers including:

- Home Care
- Supportive Living
- Long Term Care
- Transition Services
- Palliative or End of Life Care
- Adult Day Programs

*The Guide* pertains to all clients receiving AHS owned, operated and contracted continuing care services.

- As of March 31, 2019 there were 26,914 spaces in Continuing Care Designated Living Options in Alberta (excluding subacute, restorative and palliative)
- In 2018-2019, there were 127,148 Home Care Clients (cumulative quarters) representing 82,485 unique clients  
(Note: *The Guide* does not include or pertain to clients receiving private continuing care services)

### 5. Roles & Responsibilities

In the event of a pandemic outbreak, this guide provides the following information:

- Role clarification to Seniors Health Zone operations and Continuing Care Service Providers, funded by AHS ([Appendix E - Role/Responsibility Clarification](#))

- Guidelines to ensure an appropriate level of care is being provided to all clients
- How to manage bed capacity and surge capacity expectations (additional bed capacity) in the event that additional spaces are required

## 6. Primary Principles

*The Guide* is based on the two primary principles of *Care and Treat in Place* and *Surge Capacity*.

### **Care and Treat in Place:** ([Appendix F - Care and Treat in Place Guidelines](#))

- Continue to provide services to current clients
- Maintain appropriate level of care for all clients
- Continuing Care programs will manage clients in their current living environment who:
  - Develop Influenza-Like Illness (ILI) or Severe Acute Respiratory Illness (SARI)
  - Develop other medical conditions

Exception: when acute episodic illness requires surgical intervention and/or other urgent acute care services

- Decisions to discontinue admission to acute care will be determined by the Level of Activation, as directed by the Emergency Operations Center (EOC)

### **Surge Capacity:**

- Sites must comply with the *Organizational Identification of Surge Capacity Guidelines*. ([Appendix G - Surge Capacity Guidelines](#))
- Zones are responsible for identifying surge capacity of 1-2 beds for every AHS owned operated and/or contracted SL site and LTC facility ([Appendix H - Surge Capacity Identification](#)).

**Additional working principles** applicable during a pandemic response include:

- Prioritization of service provision is completed according to system capacity ([Appendix I - Service Level Recommendations](#)). The Influenza-Like Illness Services in the Home Encounters – Screening Tool ([Form 2 - Influenza Like Illness](#)) will be utilized to prioritize service need for those clients residing in their home
- Transition Services and/or Home Care will facilitate decanting (moving people) from acute care to community
- New admission to a Continuing Care Designated Living Options *should* be avoided to any site affected by pandemic illness, unless the individual has influenza-like illness. Placement activities should not stop if placement can occur safely to sites not affected by pandemic

- Infection prevention and control practices, surveillance and reporting for pandemic *may* be similar to seasonal influenza. The Government of Alberta document *Infection Prevention and Control and Workplace Health and Safety Guidelines for Health Care in Pandemic* <sup>6</sup> will be activated as directed by the Emergency Coordination Center
  - All AHS owned operated and contracted Continuing Care Service Providers are to perform a Point of Care Risk Assessment ([Form 3 - Point of Care Risk Assessment](#)) and wear face protection (PPE – as appropriate) as required

*NOTE: The cost of fit testing staff for N95 masks is the responsibility of the employer. However, in the event an influenza pandemic is pronounced, N95 masks may be provided by AHS*

- All health services, regardless of governance structure will be called upon to cooperate with the provincial and local pandemic response
- Alternate care options may be considered (e.g. informal caregivers, relocating a high needs Home Care client or Adult Day program client to a Supportive Living or Long Term Care facility, etc.)

## 7. Location(s)

Each zone representative should maintain a contact list of all Continuing Care partners funded by AHS for communication and dissemination (example [Appendix J - Communicating with Continuing Care Service Providers](#)).

*NOTE: The most recent Bed Capacity report (provided to Seniors Health Executive Directors) can be a source for this information.*

## 8. Human Resources Planning

During the peak of pandemic response, up to 30% of health care workers may be ill and absent from the workplace. Therefore, all Alberta Health Services (AHS) owned, operated and contracted Continuing Care Service Providers will be required to support the provincial and local pandemic response directives.

- Additional staff will be requested through the Zone Emergency Operations Center (ZEOC).
- AHS will forward their staff request to Human Resources who will recruit and allocate staff, according to the Health Professions Strategy and Practice *Pandemic Direct Patient Care Education* (<https://insite.albertahealthservices.ca/hpsp/Page9766.aspx>). Education material is also available at [connection.ahs.ca](http://connection.ahs.ca) under Business Resources.
- Staffing Levels and Use of Volunteers are outlined in [Appendix K- Staffing Levels and Use of Volunteers](#)
- Antiviral therapy (when deemed appropriate):

- To minimize illness and hospitalization rates, the most effective approach is to treat ill persons within 48 hours of onset of illness<sup>3</sup>
- All Continuing Care staff will have access to antiviral treatment from Alberta Health (AH) stockpiles in an attempt to minimize the impact of staff absenteeism
- Decisions regarding antiviral for prophylactic purposes will be at the discretion of the Senior Medical Officer of Health
- Funding for additional staffing costs incurred by contracted Continuing Care Service Providers *may* be considered by AHS Seniors Health for:
  - An increase in professional nursing costs needed to manage the increased client acuity
  - Increased staffing to support Care and Treat in Place
  - Increased staffing to support surge capacity
- To support Care and Treat in Place guidelines, all Continuing Care sites must establish a process for 24/7 Physician support

## 9. Infection, Prevention & Control

- Implementation of comprehensive infection prevention and control (IPC) strategies will help prevent the transmission of pandemic and other infectious diseases with or without the availability of vaccines and antivirals. IPC are seen as a foundation piece in every aspect of pandemic planning.
- Increased patient volumes and prevalence of Influenza-Like Illness (ILI) symptoms will require diligent attention to isolation precautions, health care workers exposure prevention, and department cleaning standards. Please refer to your IPC ILI Outbreak Protocols for initial Infection Prevention and Control measures. For more information please go to:
  - Infection Prevention and Control for Influenza at: <https://www.albertahealthservices.ca/info/Page6410.aspx>
  - Infection Prevention Control Continuing Care Resource manual at <https://www.albertahealthservices.ca/info/Page6854.aspx>

## 10. Supplies & Equipment

- Surge capacity equipment and supplies list ([Appendix G – Surge Capacity Guidelines](#))
- Agreements with local service providers must be established and maintained by zones and contracted Continuing Care Service Providers (e.g. oxygen providers, pharmacies, etc.)
- AHS Emergency/Disaster Management portfolio will facilitate delivery of equipment and supplies from the AHS Emergency/ Disaster Stockpile

## 11. Legislation



Legislation (where applicable) and guiding documents related to Continuing Care pandemic response includes but is not limited to:

- [Supportive Living and Long Term Care Accommodation Standards](#) (Continuation of Services (Standard 16) and Resident Safety and Security (Standard 18))
- [Continuing Care Health Service Standards \(July 2018\)](#): Staff Training (Standard 9.0), Infection Prevention and Control (Standard 11.0), Continuity of Health Care (Standard 17.0)
- [Occupational Health and Safety Acts Regulation and Code \(2009, Part Two\)](#)
- [Government of Alberta Standards for Single Use Medical Devices \(2019\)](#)
- [Government of Alberta Infection Prevention and Control Strategy \(2015\)](#)
- [Hand Hygiene for Patient and Provider Safety in Canada](#)
- [Government of Alberta Co-ordinated Home Care Program Regulation \(2003 with amendments to 2014\)](#)

## 12. Surveillance

***Surveillance takes place prior to, during and after outbreaks.***

Continuing Care operators are expected to conduct ongoing surveillance and monitoring during a pandemic response, looking for unusual clusters of illness in patients and staff, and identifying possible outbreaks. This surveillance data will drive the pandemic response and will be used to determine the level(s) of activation as well as progression through the level(s) of activation.

WHO Guidance is available here: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions>

## 13. Indicators and Required Reporting

AHS owned, operated and contracted Continuing Care providers are required to report to the Emergency Contact Center (ECC) through the Zone Emergency Operations Center (ZEOC) as required. Reporting will be available to the Medical Officer of Health (MOH) and will align with the Public Health Act. This reporting structure is identified in [Appendix D- Reporting Structure](#).

## 14. Information Management

During a pandemic response, documentation of the client status is required. Information will be provided on the Infection Prevention and Control tracking form ([Form 4 - Infection Prevention and Control - Tracking Form](#)) as well as any other information documents requested through the Zone Emergency Operations Centre.

### **RAI Assessments**

The RAI assessments provide valuable information for prioritizing client/resident care during periods of outbreak or pandemic.

- During an outbreak, RAI-HC and RAI 2.0 MDS assessments will be completed according to pre-existing schedules dependent on the client/resident status and resources available to complete the assessment.
- In the event a Pandemic is declared by the Medical Officer of Health, the program/site would continue to evaluate their ability to complete RAI assessments according to schedule. Once the pandemic is declared over, the site resumes the assessment schedule determining whether a routine or significant change assessment is required.
- For Long Term Care, Patient Care Based Funding (PCBF) outbreak business rules would be implemented when the Medical Officer of Health declares a pandemic for the zone. PCBF Quarantine protocol is provided which outlines the protocol during such events ([Appendix L - Quarantine Protocol - Patient Care Based Funding](#)).

## 15. Communications

Communication during a pandemic response may be available through a number of sources. Continuing Care sites are encouraged to follow the incident command system and report back through identified channels. In addition there may be communication available at:

- Alberta Health Services external website: [www.albertahealthservices.ca](http://www.albertahealthservices.ca)
- Alberta Health Services Insite page: <http://insite.albertahealthservices.ca/>
- Continuing Care Connection: [connection.ahs.ca](http://connection.ahs.ca)

Each Continuing Care site is encouraged to have a pandemic response communications designate to ensure information is effectively communicated with staff, clients and the public.

## 16. Levels of Activation

- Continuing Care operators can use the Pandemic Contingency Planning Responsibilities for Continuing Care Service Providers ([Form 5 - Contingency Planning](#)) as an accompanying document for working through the levels of activation and ensuring the organization has covered the necessary components for a comprehensive pandemic plan
- Continuing Care Operator's Level of Activation- Algorithm ([Form 6 - Level of Activation Algorithm](#))
- Continuing Care Operator's Levels of Activation - Checklist ([Form 7 - Level of Activation Checklist](#))

**Table 1: Levels of Activation**

LEVEL OF ACTIVATION	TRIGGERS	OVERARCHING GOAL
<b>Preparation</b>	Current Patient Volumes in Acute; Current to ↓10% in Staffing Levels; Current Functional Capacity	Increase readiness of organization, staff and public.
<b>Initiation/Surge</b>	↑10-20% in Patient Volume; ↓10-20% in Staffing Levels; ↓10-20% in Functional Capacity (* depends on type of area affected (may include community sites) and number of areas affected.)	Activation of pandemic contingency planning arrangements  Prevent nosocomial transmission and maintain biosafety.
<b>Selective Prioritization</b>	↑of 20-40%* in Patient Volumes; ↓of 20-30% in Staffing Levels; ↓of 20-30% in Functional Capacity (* depends on type of area affected (may include community sites) and number of areas affected.)	Ensure organization / zone is ready to scale up response and implement changes in triage and treatment priorities and actions can occur as soon as area(s) are affected
<b>System Wide Prioritization</b>	↑40%+ in Patient Volumes; ↓30%+ in Staffing Levels; ↓30%+ in Functional Capacity	Minimize the impact of the pandemic; sustain critical health service delivery
<b>Recovery</b>	Within 20%: <ul style="list-style-type: none"> <li>• of Surge Level Patient Volumes;</li> <li>• of Surge Level Staffing Levels;</li> <li>• of Surge Level Functional Capacity</li> </ul>	Phased recovery and evaluation
<b>Resumption</b>	Usual seasonal Patient Volume; Usual seasonal Staffing Levels; Usual Seasonal Functional Capacity	Complete recovery and Evaluation/Audit Reports

<b>Level of Activation: PREPARATION</b>		
<b>TRIGGER:</b> Current Patient Volumes Current to ↓10% in Staffing Levels Current Functional Capacity		
<b>Goal:</b> Increase readiness of organization, staff and public.		
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility (Name/position(s)/titles)</b>
Review /update Continuing Care Pandemic Operational Guide including appendices /resources Alignment with AHS Pandemic Operational Guide	Annually (minimum)	Seniors Health Emergency Management & Business Continuity Working Group Provide update to: <a href="mailto:emergencydisaster.management@albertahealthservices.ca">emergencydisaster.management@albertahealthservices.ca</a>
Review /update local (zone, program, site) Pandemic Response Plans based on Continuing Care Pandemic Operational Guide	Annually (minimum)	Zone Seniors Health program; AHS owned, operated and contracted Continuing Care Service Providers
Communicate activities related to pandemic response to Seniors Health staff, Physicians and AHS owned, operated and/ or contracted Continuing Care Service Providers	As directed by the: Medical Officer of Health (MOH) Senior Medical Officer of Health (SMOH) and/or Communications	Community, Seniors, Addictions and Mental Health (CSAMH): <ul style="list-style-type: none"> <li>• Director - Continuing Care Capacity, Funding and Workforce.</li> <li>• Medical Director</li> </ul> Zone Seniors Health Executive Director Zone Seniors Health Medical Director
Review and update Seniors Health staff fan out lists	Annually (minimum)	Zone Seniors Health (Program Directors, Facility Managers, and/or designates).
Review and update the Continuing Care physician staffing plans	Annually	Zone Seniors Health Medical Director

<b>Level of Activation:</b> PREPARATION		
<b>TRIGGER:</b> Current Patient Volumes Current to ↓10% in Staffing Levels Current Functional Capacity		
<b>Goal:</b> Increase readiness of organization, staff and public.		
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility (Name/position(s)/titles)</b>
Review and update Continuing Care Physician fan out list	Annually	Zone Seniors Health Medical Director
Review strategies for the possible development of Home Care Intravenous/Total Parental Nutrition (TPN) Teams ( <a href="#">Form 8 - Pandemic Response IV Hydration for Continuing Care Clients</a> )	Annually	Zone Seniors Health Executive Directors
Support orientation and education of Continuing Care staff regarding Personal Preparedness and Influenza Care on a regular basis as per regular orientation and education programs	Ongoing	AHS educators; contracted provider educators
Review, update, and circulate Outbreak Management documents <a href="https://www.albertahealthservices.ca/info/Page6421.aspx">https://www.albertahealthservices.ca/info/Page6421.aspx</a>	Annually	Infection Prevention and Control Pandemic Response Plan Working Group; Public Health – Communicable Disease Control
Promote and increase communication to staff within AHS owned, operated and contracted Continuing Care providers regarding Self-Care Practices and Respiratory Etiquette for Influenza and Influenza-Like Illnesses	Ongoing	Continuing Care Infection Prevention and Control Group; Facility Managers; Program Managers; AHS Communications

<b>Level of Activation:</b> PREPARATION		
<b>TRIGGER:</b> Current Patient Volumes Current to ↓10% in Staffing Levels Current Functional Capacity		
<b>Goal:</b> Increase readiness of organization, staff and public.		
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility (Name/position(s)/titles)</b>
Promote and facilitate annual influenza vaccination for staff within AHS owned, operated and contracted Continuing Care providers	Annually	Medical Officer of Health; Public Health; Program Managers; Facility Managers; Occupational Health and Safety; AHS Communications
Promote and facilitate annual influenza vaccination for all Continuing Care clients	Annually	Medical Officer of Health; Public Health; Program Managers; Facility Managers; Occupational Health and Safety; AHS Communications
Identify Surge Capacity for Long Term Care and Supportive Living ( <a href="#">Appendix G</a> and <a href="#">Appendix H</a> and <a href="#">Form 1</a> )	Annually or upon identification of potential impending pandemic response as identified by the Chief Medical Officer of Health/Seniors Medical Officer of Health	Zone Seniors Health Executive Director, and/or designate
Review program/site pandemic strategy plan to maximize capacity (i.e. potential discharges or need for additional resources, etc.)	Annually	Program Managers; Facility Managers
Ensure alignment with Human Resources Pandemic Response Plan to address staffing models 'Staffing Levels and Use of Volunteers' ( <a href="#">Appendix K - Staffing Levels and Use of Volunteers</a> )	Annually	Seniors Health Emergency Management and Business Continuity Working Group; Human Resources; Program Managers; Facility Managers
Initiate strategy for conducting a mass vaccination program in Continuing Care in relation to changing Level(s) of Activation	Annually	Medical Officer of Health; Zone Seniors Health Executive Director

<b>Level of Activation:</b> PREPARATION		
<b>TRIGGER:</b> Current Patient Volumes Current to ↓10% in Staffing Levels Current Functional Capacity		
<b>Goal:</b> Increase readiness of organization, staff and public.		
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility (Name/position(s)/titles)</b>
Review information, forms, and processes for tracking clients	Annually	Program Managers; Facility Managers
Review information, forms, and processes for tracking human resources	Annually	Program Managers; Facility Managers; Human Resources
Review information, forms, and processes for tracking equipment and supplies	Annually	Program Managers; Facility Managers
Ensure Service Level Recommendations ( <a href="#">Appendix I</a> ) are identified / updated for area/program	Annually	Program Managers; Facility Managers
Review Recovery and Resumption Plans	Annually	Zone Seniors Health Executive Director or/ designate
Participate in tabletop exercise of Pandemic Plan, as applicable	As determined by Executive Coordinator Council	Emergency/Disaster Management; Medical Officer of Health; Zone Emergency Operations Center; AHS owned, operated, and/or contracted Continuing Care Service Providers

<b>Level of Activation:</b> INITIATION / SURGE		
<b>TRIGGER:</b> ↑10-20% in Patient Volumes* ↓10-20% in Staffing levels ↓ 10-20% in Functional Capacity  * Depends on type of area affected (may include community sites) and number of areas affected		
<b>Goal:</b> - Activation of pandemic contingency planning arrangements - Prevent nosocomial transmission and maintain bio-safety		
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>

		<b>Zone Emergency Operations Centre</b>	<b>AHS Emergency Coordination Centre</b>
Communicate change in Level of Activation to <b>INITIATION / SURGE</b> to physicians and staff of AHS owned, operated and contracted Continuing Care Service Providers	Senior Medical Officer of Health /Communications when declared on notification by Alberta Health	Zone Seniors Health Executive Director; Zone Seniors Health Medical Director	Director - Continuing Care Capacity, Funding and Workforce-Community, Seniors, Addictions & Mental Health (CSAMH)
Establish AHS Emergency Coordination Centre (ECC)	At level of activation initiation and ongoing		AHS Executive Leadership
Establish Zone Emergency Operations Centre (ZEOC), as necessary	At level of activation as necessary	Zone Seniors Health Executive Director; ZEOC designates	Director - Continuing Care Capacity, Funding and Workforce-CSAMH; Medical Director, CSAMH
Establish Facility/ Site Command Posts(s), as necessary	In consultation with ZEOC	Zone Seniors Health Executive Director; ZEOC	
Initiate Care and Treat in Place Plan ( <a href="#">Appendix F</a> ), as needed. Admission decisions are communicated by MOH	At notification of level of activation	Zone Seniors Health Executive Director	
Begin to track cases on the Outbreak Tracking Form ( <a href="#">Form 4</a> ) as per IPC <i>Outbreak Management Guidelines</i>	As per reporting guidelines	IPC Group and Public Health	
Communicate with physicians and Continuing Care staff of AHS owned, operated and contracted service providers regarding Pandemic Assessment Criteria and Notification Process	At INITIATION/SURGE level of activation once confirmed by CMOH/SMOH; ongoing as required	Zone Seniors Health Executive Director; Zone Seniors Health Medical Director	Director - Continuing Care Capacity, Funding and Workforce-CSAMH; Medical Director, CSAMH



<b>Level of Activation: INITIATION / SURGE</b>			
<b>TRIGGER:</b> <ul style="list-style-type: none"> <li>↑10-20% in Patient Volumes*</li> <li>↓10-20% in Staffing levels</li> <li>↓ 10-20% in Functional Capacity</li> </ul> <p>* Depends on type of area affected (may include community sites) and number of areas affected</p>			
<b>Goal:</b> <ul style="list-style-type: none"> <li>- Activation of pandemic contingency planning arrangements</li> <li>- Prevent nosocomial transmission and maintain bio-safety</li> </ul>			
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>	
		<b>Zone Emergency Operations Centre</b>	<b>AHS Emergency Coordination Centre</b>
Initiate initial Infection Prevention and Control (IPC) measures and recommendations for Visitors as per <i>IPC Outbreak Management Guidelines</i>	At notification of INITIATION/ SURGE level of activation	Program Managers; Facility Managers	
Implement and schedule IPC skills and respiratory etiquette/routine practices and additional precautions for personnel and others as needed	At level of activation initiation	Program Managers; Facility Managers	
Initiate a plan for providing <i>Just in Time training- Comfort care Level 1 skills</i> . Training module is available at: <ul style="list-style-type: none"> <li>• Insite: <a href="https://insite.albertahealthservices.ca/main/assets/tms/hpsp/tms-hpsp-mod-level1-comfort-care.pdf">https://insite.albertahealthservices.ca/main/assets/tms/hpsp/tms-hpsp-mod-level1-comfort-care.pdf</a></li> <li>• Continuing Care Connection: <a href="http://connection.ahs.ca">connection.ahs.ca</a></li> </ul>	At notification of INITIATION/SURGE level of activation	AHS educators; contracted provider educators	
<i>Prepare Visual Care Plans</i> for bedside use ( <a href="#">Form 10</a> )	At notification of level of activation	AHS educators; contracted provider educators; Program Managers; Facility Managers	

<b>Level of Activation: INITIATION / SURGE</b>			
<b>TRIGGER:</b> <ul style="list-style-type: none"> <li>↑10-20% in Patient Volumes*</li> <li>↓10-20% in Staffing levels</li> <li>↓ 10-20% in Functional Capacity</li> </ul> * Depends on type of area affected (may include community sites) and number of areas affected			
<b>Goal:</b> <ul style="list-style-type: none"> <li>- Activation of pandemic contingency planning arrangements</li> <li>- Prevent nosocomial transmission and maintain bio-safety</li> </ul>			
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>	
		<b>Zone Emergency Operations Centre</b>	<b>AHS Emergency Coordination Centre</b>
Identify clients to be discharged to community and identify needs for community support ( <a href="#">Appendix N</a> )	At notification of level of activation	Program Managers; Facility Managers; Transition Services; Access Centre; Home Care	
Report and monitor Continuing Care Designated Living Option waitlist. Admission to Designated Living Option if client cannot be maintained in current living environment	At level of activation; ongoing as required	Transition Services or designate	
Initiate and communicate <i>changes to normal operating procedure</i> as needed ( <a href="#">Appendix O</a> )	At notification of level of activation	Zone Seniors Health Executive Director; Transition Services; Program Managers; Facility Managers	
Initiate Antiviral administration program (Based on Federal antiviral criteria and Antiviral Administration Plan)	As directed by federal and provincial authority (Alberta Health) or MOH/SMOH	Zone Seniors Health Executive Director	Medical Officer of Health; Public Health leads; Medical Director
Activate and communicate with Pandemic Cost Centre; process all eligible billing costs, as necessary	At level of activation initiation and ongoing	Zone Seniors Health Executive Director and/or designate	

<b>Level of Activation:</b> <b>INITIATION / SURGE</b>			
<b>TRIGGER:</b> ↑10-20% in Patient Volumes* ↓10-20% in Staffing levels ↓ 10-20% in Functional Capacity * Depends on type of area affected (may include community sites) and number of areas affected			
<b>Goal:</b> - Activation of pandemic contingency planning arrangements - Prevent nosocomial transmission and maintain bio-safety			
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>	
		<b>Zone Emergency Operations Centre</b>	<b>AHS Emergency Coordination Centre</b>
Prepare Business Recovery and Resumption Plan and Toolkit for Implementation	At notification of level of activation	ZEOC; Zone Seniors Health Executive Director	Director - Continuing Care Capacity, Funding and Workforce- (CSAMH)

<b>Level of Activation:</b> <b>SELECTIVE PRIORITIZATION</b>			
<b>TRIGGER:</b> ↑of 20-40%* in Patient Volumes ↓of 20-30% in Staffing Levels ↓of 20-30% in Functional Capacity *Depends on type of area affected (may include community sites) and number of areas affected			
<b>Goal:</b> Ensure organization / zone is ready to scale up response and implement changes in triage and treatment priorities and actions can occur as soon as area(s) are affected			
Actions	Frequency	Responsibility	
		Zone Emergency Operations Centre	AHS Emergency Coordination Centre
Communicate change in Level of Activation to <b>SELECTIVE PRIORITIZATION</b> to physicians and staff of AHS owned, operated and contracted Continuing Care Service Providers	<ul style="list-style-type: none"> <li>• Upon direction from Alberta Health;</li> <li>• As directed by SMOH/ communications</li> </ul>	Zone Seniors Health Executive Director; Zone Medical Director	Director - Continuing Care Capacity, Funding and Workforce - Community, Seniors, Addictions & Mental Health (CSAMH); Medical Director, CSAMH
Establish AHS Emergency Coordination Centre (ECC)	At level of activation initiation and ongoing	Zone Seniors Health Executive Director	
Establish Zone Emergency Operations Centre (ZEOC)	At level of activation initiation and ongoing		Medical Officer of Health; Executive Director Emergency/ Disaster Management
Initiate documentation (Tracking Process) at ECCs and EOCs including: <ul style="list-style-type: none"> <li>• Clients</li> <li>• Equipment</li> <li>• Supplies</li> <li>• Human Resources</li> <li>• Finance</li> </ul>	At level of activation initiation and ongoing	Zone Seniors Health Executive Director	Director - Continuing Care Capacity, Funding and Workforce- CSAMH; Medical Director, CSAMH

<b>Level of Activation:</b> <b>SELECTIVE PRIORITIZATION</b>			
<b>TRIGGER:</b> ↑of 20-40%* in Patient Volumes ↓of 20-30% in Staffing Levels ↓of 20-30% in Functional Capacity  *Depends on type of area affected (may include community sites) and number of areas affected			
<b>Goal:</b> Ensure organization / zone is ready to scale up response and implement changes in triage and treatment priorities and actions can occur as soon as area(s) are affected			
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>	
		<b>Zone Emergency Operations Centre</b>	<b>AHS Emergency Coordination Centre</b>
Initiate Facility /Site discharge coordination group	At level of activation initiation and ongoing	Program Directors; Facility Managers	
Deploy staff and volunteers according to Human Resource Pandemic Manual	At level of activation initiation and ongoing	Human Resources; Program Directors; Facility Managers	
Activate enhanced occupational health surveillance	At level of activation initiation and ongoing	Program Directors; Facility Managers	
Implement Business Recovery and Resumptions Plan and Task List		Program Directors; Facility Managers	Director - Continuing Care Capacity, Funding and Workforce-Community, Seniors, Addictions & Mental Health (CSAMH) or designate

<b>Level of Activation:</b> <b>SYSTEM WIDE PRIORITIZATION</b>			
<b>TRIGGER:</b> ↑40%+ in Patient Volumes ↓30%+ in Staffing Levels ↓30%+ in Functional Capacity			
<b>Goal:</b> Minimize the impact of the pandemic; sustain critical health service delivery			
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>	
		<b>Zone Emergency Operations Centre</b>	<b>AHS Emergency Coordination Centre</b>
Communicate change in Level of Activation to <b>SYSTEM WIDE PRIORITIZATION</b> to physicians and staff of AHS owned, operated and Contracted Continuing Care Service Providers	Upon notification from Alberta Health	Zone Seniors Health Executive Director; Zone Seniors Health Medical Director	Director - Continuing Care Capacity, Funding and Workforce - Community, Seniors, Addictions & Mental Health (CSAMH); Medical Director, CSAMH
Review daily pandemic status update reports received from Continuing Care sites and programs	Designated time daily	Zone Seniors Health Executive Director; Program Directors; Facility Managers	Director - Continuing Care Capacity, Funding and Workforce - CSAMH; Medical Director, CSAMH
Adjust staffing model, implement as needed ( <a href="#">Appendix K</a> )	On activation of level of activation	Program Directors; Facility Managers	
Activate Physician Deployment Plan as per Physician Pandemic Plan	On initiation of Level of Activation	Zone Seniors Health Medical Director	
Communicate Alternative Care Centre(s) (ACCs) locations, principles and guidelines to physicians and staff of AHS owned, operated and Contracted Continuing Care Service Providers	Upon direction of ECC	Zone Seniors Health Executive Director; Communications	
Maintain Business Recovery and Resumptions Plan and Task List		Program Directors; Facility Managers	Director - Continuing Care Capacity, Funding and Workforce - CSAMH and/or designate

<b>Level of Activation:</b>				<b>RECOVERY</b>	
<b>TRIGGER:</b>				Within 20% of Surge Level Patient Volumes within 20% of Surge Level Staffing Levels within 20% of Surge Level Functional Capacity	
<b>Goal:</b>				Phased recovery and evaluation	
<b>Actions</b>		<b>Frequency</b>	<b>Responsibility</b>		
			<b>Zone Emergency Operations Centre</b>		<b>AHS Emergency Coordination Centre</b>
Communicate change in Level of Activation to <b>RECOVERY</b> guidelines to physicians and staff of AHS owned, operated and Contracted Continuing Care Service Providers		Upon initiation of level of activation	Zone Seniors Health Executive Director; Zone Seniors Health Medical Director; Communications		Director - Continuing Care Capacity, Funding and Workforce - Community, Seniors, Addictions & Mental Health (CSAMH); Medical Director, CSAMH
Implement phased approach to resumption of pre-pandemic service delivery based on assessment of current scenario and available resources. (i.e. resumption of non-essential service and admission to Designated Living Options)		On initiation of level of activation	Zone Seniors Health Executive Director; Program Directors; Facility Managers		
Implement strategy to close AHS ECC, ZEOC and Facility/ Site Command Posts		Upon direction from Alberta Health, CMOH/ SMOH and/or ECC			Director- Continuing Care Capacity, Funding and Workforce - CSAMH; EOC
Implement formal staff recognition program		Upon direction and provision of tools from Human Resources	Zone Seniors Health Executive Director; Zone Seniors Health Medical Director; Program Directors; Facility Managers		Director - Continuing Care Capacity, Funding and Workforce - CSAMH; Medical Director, CSAMH

<b>Level of Activation: RESUMPTION</b>		
Activities occur within 6 months of initiation of the level of activation		
<b>TRIGGER:</b>		
Usual seasonal patient volume usual seasonal Staffing Levels usual seasonal Functional Capacity		
<b>Goal:</b>		
Complete recovery and Evaluation/Audit Reports		
<b>Actions</b>	<b>Frequency</b>	<b>Responsibility</b>
Communication change in Level of Activation to <b>RESUMPTION</b> to physicians and staff of AHS owned/operated and Contracted Continuing Care Service Providers	On initiation of level of activation	Zone Seniors Health Executive Director; Zone Seniors Health Medical Director
Participate in Provincial and/or Zone post-incident debriefing; analysis of all components of the Pandemic Plan as applicable	Within 6 months of declared level of activation	Zone Seniors Health Executive Director or designate; Zone Seniors Health Medical Director
Complete Evaluation / Audit Reports	Within 6 months of declared level of activation	Program Directors; Facility Managers
Close Business Recovery and Resumption Plan and Completed Task List	Within 6 months of declaration of level of activation	Zone Seniors Health Executive Director
Develop plan for implementation of recommendations from Evaluation / Audit Reports	Within 6 weeks of completion and release of Evaluation / Audit Reports	Director - Continuing Care Capacity, Funding and Workforce - Community, Seniors, Addictions & Mental Health (CSAMH); Medical Director, CSAMH
Review and revise Continuing Care Pandemic Operational Guide	Within 9 month of declared level of activation	Seniors Health Emergency Management & Business Continuity Working Group; Zone Seniors Health



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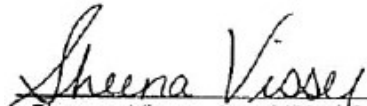
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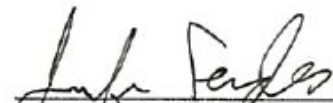
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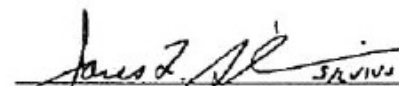
  
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## Appendix A: Glossary of Terms

**Adult Day Programs (ADP)** – programs designed for adults (over 18 years of age) who may have physical and/or memory challenges and/or are living with a chronic illness. ADPs play a key role in allowing individuals to remain living in the community as long as possible by optimizing the level of physical, spiritual, social and emotional function through provision of support, respite, and/or education for informal caregivers.

**Alberta Emergency Management Agency (AEMA)** – a department within the provincial government that assists with Emergency/Disaster Management planning at the municipal level.

**Alternate Care Centre (ACC)** – location established during pandemic where care is provided for individuals who do not require acute hospital services and who are unable to be maintained or able to maintain themselves in their home. ACCs will provide health care services to clients with influenza-like-illness (ILI) and clients without ILI symptoms.

**Care and Treat in Place** – continue to provide services to current clients' to maintain an appropriate level of care. ([Appendix F- Care and Treat in Place Guidelines](#))

**Client(s)** – individual(s) receiving publicly funded Continuing Care health services through community Home Care programs or residing in a supportive living or long-term care facilities.

**Chief Medical Officer of Health (CMOH)** means a Medical Officer of Health under the Alberta Health structure. See definition under Medical Officer of Health.

**Continuing Care** – an integrated system of community based programs including Adult Day Programs, Home Care, Coordinated Access/ Transition Services, Supportive Living, Long Term Care and Palliative Care or End of Life Care. Continuing Care clients are not defined by age, diagnosis or the length of time they may require service, but by their assessed need for care.

**Continuing Care Designated Living Option (Designated Living Option)** – means residential accommodation that provides publicly funded health and support services appropriate to meet the patient's Assessed Unmet Needs. The level of care is accessed through a standardized assessment and single point of entry process and consists of Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4) and Designated Supportive Living Level 4 Dementia (DSL4D) and Long Term Care (LTC).

**Continuing Care Contracted Operators** – a person or organization that provides Continuing Care accommodations. For-profit settings are owned by an individual or corporation and run for profit. Not-for-profit facilities are owned and operated by a religious organization or voluntary, non-governmental and non-religious bodies. AHS and the Government of Alberta can also be operators.

**Coronavirus Disease** – COVID-19 (i.e. **Severe Acute Respiratory Syndrome Coronavirus 2** – SARS-CoV-2)

**Designated Supportive Living Level 3 (SL3)** – a living option where AHS controls access to a specific number of beds according to a contractual agreement between AHS and the operator. Twenty-four hour on-site scheduled and unscheduled personal care and support services are provided by Health Care Aides. Professional health services including Registered Nurse services with 24 hour on-call availability, case management and other consultative services are provided through AHS.

**Designated Supportive Living Level 4 (SL4)** – a living option where AHS controls access to a specific number of beds according to a contractual agreement between AHS and the operator. Twenty-four hour onsite scheduled and unscheduled professional and personal care and support services are provided by Licensed Practical Nurses and Health Care Aides. Professional health services including Registered Nurse services with 24 hour on-call availability, case management and other consultative services are provided through AHS.

**Designated Supportive Living Level 4 Dementia (SL4D)** – a living option where services for individuals with moderate dementia that will progress to later stages or other forms of cognitive impairment who require a secure therapeutic environment.

**Emergency/Disaster Management (EDM)** – department responsible for the oversight and development of AHS emergency response plans (including pandemic response plans). EDM is responsible for collaborating with internal and external partners to ensure operations can be maintained during emergencies (including pandemic response).

**Emergency Coordination Centre (ECC)** – the physical location for coordination of provincial AHS efforts aimed at managing a large scale event including, but not necessarily limited, to: expediting decision making, reducing duplication and redundancies, defining/clarifying AHS objectives, managing data and communications, and establishing standards/direction relative to a response.

**Executive Director, Seniors Health** – refers to the executive leadership for the provincial Seniors Health strategy team unless otherwise noted. I.e. Zone Executive Directors, Seniors Health will be indicated as such.

**Home Care (HC)** – is a publicly funded health care and support service provided to eligible clients as governed by the *Alberta Home Care Program Regulations* of the *Public Health Act*. These services support the wellness and independence of clients. The goal is to help clients remain safe and independent in their home or care setting for as long as possible. Alberta's Home Care program supports Albertans of all ages and includes an array of services including health promotion and teaching, treatments, end of life care, rehabilitation, home support and maintenance, assistance to maintain social connections, and support for families or others who help the client out. The Home Care Program organizes health care service delivery with other health services that are available in the community.

**Home Living** – is the primary housing option for persons who are able to live independently with minimal support services. Home living is the housing option for persons who choose to and who are able to maintain active, healthy, independent living while remaining in their home as long as possible. In order to support continued independent living, basic home care services may be provided and/or the individual can purchase services from another agency. The home

living sector is one of three care streams under Alberta's Continuing Care system (the other two being: supportive living and facility based long-term care).

**Incident Management System (IMS)** – provides a comprehensive, standardized framework with a governance structure that is sufficiently flexible and scalable as to be applicable across the full spectrum of potential incidents regardless of cause, size, location or complexity. The system allows for an integrated response in preparation, response and recovery from the effects of a variety of emergencies (including pandemic).

**Incident Command System (ICS)** – the system utilizes an organizational structure based on the Incident Command System (ICS), which enables rapid integration and connectivity between sites, services, zones, external partners and stakeholders. It defines the roles and responsibilities of personnel and the operating procedures to be used in the management and direction of emergencies and disasters. The structure is intended to foster cohesion between AHS, Alberta Health (AH) and other response organizations.

**Influenza** – a highly contagious infection of the respiratory tract (nose, throat, bronchial tubes, lungs) caused by the influenza virus. The illness is characterized by sudden onset of fever, cough, sore throat, malaise and general aches, and also by nausea/vomiting and diarrhea in children. In the very young, fever may not be prominent. In geriatric age groups, persons often experience fever or feverishness with chills, but these symptoms may not be prominent. Influenza viruses cause annual influenza epidemics and occasional worldwide influenza pandemics.

**Influenza Assessment Centre (IAC)** – a site (for influenza pandemic planning) that is not a currently established health care site or that is a site that usually offers a different type or level of care. During influenza pandemic, it is expected that influenza assessment centers will be needed to provide assessment for influenza patients and will focus on assessment, antiviral, education and potentially hydration of these patients. Also known as a non-traditional care site.

**Influenza Virus** – there are three types of influenza viruses: A, B and C. Subcategories of influenza (subtypes) are based on the configuration of two proteins on the virus surface – hemagglutinin (H) and neuraminidase (N). Subtypes of influenza A virus known to readily infect humans include H1N1, H2N2, H3N2. Avian influenza A viruses (H5N1, H7N7, H7N3, and H9N2) have also recently been shown to infect humans, although they do not do so readily. The threat of pandemic is related to the introduction of a new subtype of influenza A into the human population.

**Influenza Like Illness (ILI)** – onset of subjective fever, cough or sore throat.

**Level of Activation (LoA)** – coordinated pandemic response determined by the prevalence of Influenza-Like Illness, the absenteeism of staff and therefore the overall decrease in system functional capacity.

**Long Term Care (LTC)** – facilities are a congregate care option for individuals with complex, unpredictable medical needs who require 24 hour on-site Registered Nurse assessment and/or treatment. In addition, professional services may be provided by Licensed Practical Nurses and 24 hour on-site unscheduled and scheduled personal care and support are provided by Health Care Aides. Case Management, Registered Nursing, Rehabilitation Therapy and other

consultative services are provided on-site. Long-term care facilities include “nursing homes” under the Nursing Homes Act and “auxiliary hospitals” under the Hospitals Act. LTC is one of three care streams under Alberta’s Continuing Care system (the other two being: Home Living and Supportive Living).

**Medical Director, Seniors Health** – refers to the executive leadership physician for the provincial Seniors Health strategy team unless otherwise noted. I.e. Zone Medical Directors will be indicated as such.

**Medical Officer of Health (MOH)** All Medical Officers of Health in Alberta are medical specialists who carry out multiple functions within the health system. The scope of their practice is population based rather than patient based. They are responsible for monitoring, assessing and reporting on the health status of the populations they serve. Under the Public Health Act, they have certain statutory duties that they are mandated to carry out.

**Oseltamivir** – an antiviral drug effective against influenza A and B viruses that inhibits the neuraminidase protein, effectively trapping the influenza virus within the host cell and preventing it from infecting new cells. This can help in preventing infection (prophylaxis) or in reducing the duration and severity of illness once infected. It is effective if treatment is started within 48 hours of symptom onset. In Canada and the USA, Oseltamivir is sold under the brand name Tamiflu®.

**Pandemic** – an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people

**Palliative or End of Life Care** – is a continuum of care that enables a client with a life limiting illness to receive integrated and coordinated care, which incorporates the client and their family’s values, preferences, and goals from early diagnosis to End-of-Life, including bereavement. It is both a philosophy and an approach to care that enables all individuals with a life-limiting and/or life-threatening illness to receive integrated and co-ordinated care across the continuum. This care incorporates patient and family values, preferences and goals of care, and spans the disease process from early diagnosis to end of life, including bereavement Palliative care aims to improve the quality of life for patients and families facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions.

**Patient Care Based Funding (PCBF)** – is a funding system based on overall client needs as assessed by a standardized, comprehensive assessment tool (interRAI). The method is used by funders to pay for desired health services. It is an output- based allocation method which classifies residents/patients by clinical acuity and resource use to enable consistent and appropriate funding. PCBF provides funding based on care provided to residents/patients as opposed to funding a specific type of bed. The key objective of PCBF is to align incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels.

**Personal Protective Equipment (PPE)** – includes all protective clothing and work accessories (e.g. gloves, gowns, face protection like N95 masks) designed to protect employees from work place hazards.

**Public Health Act**— an Alberta provincial statute that mandates Medical Officers of Health (MOsH) and regulates matters of communicable disease control and sanitation for the purpose of protection of the public from health hazards.

**Senior Medical Officer of Health (SMOH)** – is a Medical Officer of Health within Alberta Health Services’ structure. All Medical Officers of Health report directly to the Senior Medical Officer of Health who is the highest level Medical Officer of Health Executive accountable to the Senior Medical Physician Executive.

**Supportive Living (SL)** – is one of three care streams under Alberta’s Continuing Care system. The other two streams being: home living and facility based long-term care. Supportive living provides a home-like setting where people can maintain control over their lives while also receiving the support they need. The buildings are specifically designed with common areas and features to allow individuals to “age in place.” Supportive living promotes residents’ independence and aging in place through the provision of services such as 24-hour monitoring, emergency response, security, meals, and housekeeping and life-enrichment activities. Publicly-funded personal care and health services are provided to supportive living residents based on assessed unmet needs. Alberta Health Services contracts for supportive living in three “levels”: Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4), and Designated Supportive Living Level 4 Dementia (DSL4D).

**Surge Capacity** – A health care system’s ability to rapidly expand beyond normal services to meet the increased demand for qualified personnel, medical care, and public health in the event of large-scale public health emergencies or disasters. Additional bed based capacity identified and/or located within existing health care sites

**Surveillance** – Influenza surveillance is required to identify when, where, and which influenza viruses are circulating, the intensity and impact of influenza activity, and high-risk populations.

**Tamiflu®** – name under which oseltamivir is marketed in Canada and the USA (see Oseltamivir).

**Total Parenteral Nutrition (TPN)** – is the intravenous (IV) infusion of appropriate amounts of basic nutrients to sustain nutritional balance when gastro-intestinal tract feeding is impossible, inadequate or hazardous.

**Transition Services** – provides coordinated access to Continuing Care programs and supports all programs by providing information and access, intake and assessment, and transitional support. The Transition Services Coordinator also assists in developing a plan of discharge for individuals to remain safe and independent when returning to their home.

**Zone Emergency Operations Centre (ZEOC)** – the physical location where zone representatives come together during an emergency to undertake the command and control of response and recovery actions and resources of the sites and services within the zone. The ZEOC also acts as a liaison between the site/service Command Posts and local partners and stakeholders.

**Zone Executive Leadership (ZEL)** – Leadership team established in the zone.



**World Health Organization (WHO)** – specialized agency of the United Nations generally concerned with health and health care.

**Appendix B: Governance Structure and Working Group Membership**

The *Continuing Care Pandemic Operational Guide* has been:

- Developed by the Seniors Health Emergency Management and Business Continuity Working Group;
- Sponsored by the Director- Continuing Care Capacity, Funding and Workforce and the Medical Director, Community, Seniors, Addictions and Mental Health;
- Approved by the membership of the Integrated Continuing Care Steering Committee
- Reviewed by the AHS COVID-19 Continuing Care Working Group

Special thanks to the many contributors from: Seniors Health Provincial, Emergency and Disaster Management, Zone and PCBF teams that supported our quality improvement initiatives and provided content expertise for this guide.

## Appendix C: Incident Management System - Overview

### AHS Emergency and Disaster Management (2020)

The AHS IMS governance structure is designed to allow for flexibility and scalability relative to the nature and scope of the event. A strategic command network, incorporating an AHS Emergency Coordination Centre (AHS ECC) five Zone Emergency Operations Centre's (ZEOC), and a number of Site/Service and Corporate Command Posts (CP), will support coordination of efforts. For the purpose of AHS these are further defined as follows:

- **AHS ECC:** a pre-designated location for coordination of Provincial AHS efforts aimed at managing large scale emergencies and disasters. Its primary role is to expedite decision making, reduce duplication and redundancies, define/clarify AHS objectives, manage data and communications, and establish standards/direction relative to a response.
- **ZEOC:** the physical location where zone representatives come together during an emergency to coordinate response and recovery actions and resources of the Sites and Services within the zone. The ZEOC liaises with the Site/Service CP and with local partners and stakeholders.
- **Site/Service/Corporate CP:** provides overall management and coordination of emergency operations at individual urban acute care sites, rural acute care sites and/or community and corporate service areas.

These centers can be activated independently to deal with local/zone issues or as part of a strategic command network to support provincial AHS response activities and AHS/Multi-agency Coordination.

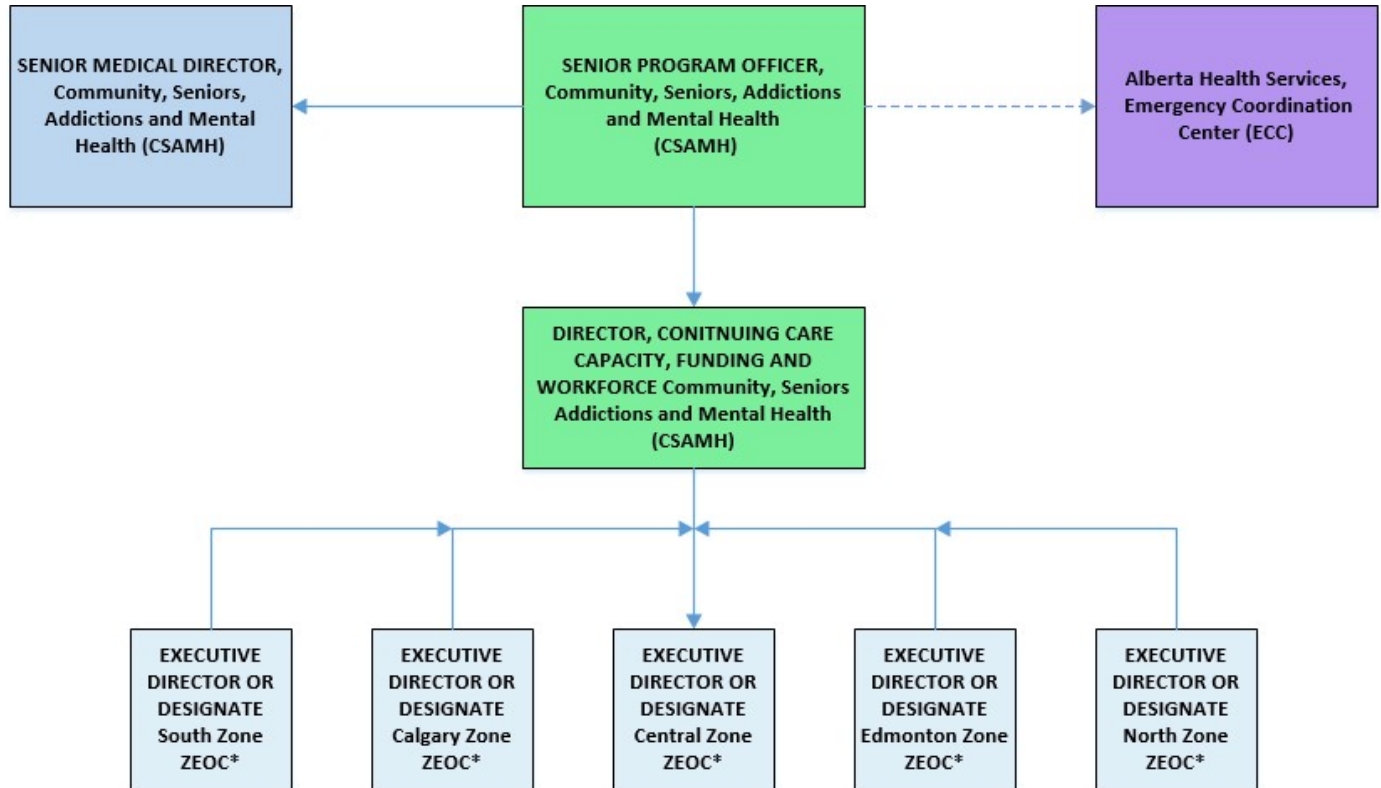
The overall objective of the governance structure is to ensure the effective management of efforts involved in responding to, and recovering from, major stressing events. Specifically this will include:

- Overall management and coordination of emergency operations at a Site/Service level, and/or Corporate/Provincial level.
- Coordinating and maintaining liaison with appropriate Federal, Provincial, and Municipal government departments, with partners, key stakeholder agencies and appropriate private sector organizations.
- Managing the acquisition and allocation of resources, supplies and other related support.
- Establishing priorities and adjudicating conflicting demands for resources and/or support.
- Coordinating inter-jurisdictional mutual aid.
- Activating and using communication systems.
- Preparing and disseminating emergency public information; disseminating community warnings.
- Collecting, evaluating and disseminating information and essential data.

- Responding to requests for human resources and other support.
- Restoring essential health services.
- Recovering from the incident as an organization.

Each Continuing Care site is encouraged to have a pandemic response governance structure that supports an overall incident command system approach (above) to ensure pandemic information is effectively communicated with staff, clients and the public.

**Appendix D: Reporting Structure Diagram**



\*ZEOC: Zone Emergency Operations Center (Zone Pandemic Response Plan to be followed).

Updated March 2020

Appendix E: Role/Responsibility Clarification

**AHS Continuing Care Pandemic Response Plan  
Roles & Responsibilities**

Group	Responsibility
<b>Seniors Health Emergency Management and Business Continuity Working Group</b>	Contributes to the review and revision of the Continuing Care Pandemic Operational Guide: <ul style="list-style-type: none"> <li>• with consideration of the AHS Pandemic Operational Guide</li> <li>• to promote a collective and integrated pandemic response</li> <li>• in consideration of the available resources within Continuing Care in the respective zone</li> </ul>
<b>Zone Emergency Operations Centre (ZEOC)</b>	<ul style="list-style-type: none"> <li>• Coordinates the response of <u>all AHS owned, operated and Contracted</u> Continuing Care Service Providers.</li> <li>• Identifies an implementation and communication strategy reflective of zone resources</li> <li>• Monitors risks associated with pandemic planning within the zone, programs and sites</li> <li>• Establishes physician coverage in Continuing Care in collaboration with Zone Medical Directors</li> <li>• Identifies a contact for the ECC to liaise with in the event of a pandemic response</li> <li>• Assigns responsibilities within the zone in the event of a pandemic response</li> </ul>
<b>All Continuing Care programs (Home Care, Supportive Living and Facility Living)</b>	<ul style="list-style-type: none"> <li>• Support ZEOC in implementation of a pandemic response as requested</li> <li>• Identify resources within the respective program area.</li> <li>• Support Continuing Care clients through Care and Treat in Place strategies</li> <li>• Provide Comfort Care training Module for physicians, staff and volunteers</li> <li>• Identify risk(s) associated with pandemic response to Zone EOC</li> <li>• Identify clients who need to be transferred to a congregate living environment as applicable</li> <li>• Identify a communication strategy in relation to a pandemic response to inform staff, clients, family and public.</li> <li>• Identify program and site contacts as required by the Zone EOC</li> <li>• Identify capacity statistics (ie. spaces in Supportive Living, spaces in Long Term Care and total number of Home Care clients)</li> <li>• Track expenses related to pandemic response (e.g. staffing, overtime, equipment and supplies, pharmacy costs)</li> </ul>

<b>Coordinated</b>	<ul style="list-style-type: none"> <li>• Facilitate decanting (moving) of clients from acute care to</li> </ul>
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<b>Access/Transition Services</b>	<p>community</p> <ul style="list-style-type: none"> <li>Collaborate with Zone Seniors Health to coordinate provision of service through Care and Treat in Place strategies</li> </ul>
<b>Emergency Operating Centres (EOC)</b>	<ul style="list-style-type: none"> <li>Collaborate with the Medical Officer(s) of Health (MOH) to monitor the influenza</li> <li>Collaborate with the MOH to coordinate a pandemic response</li> <li>Provide direction to Zone EOCs given the Level of Activation</li> <li>Develop a communication strategy in relation to a pandemic response to inform staff, clients, family and public</li> </ul>
<b>Director- Continuing Care Capacity, Funding and Workforce</b>	<ul style="list-style-type: none"> <li>Approve the Continuing Care Pandemic Operational Guide</li> <li>Contact Zone EOC to initiate a pandemic response as identified by the ECC</li> <li>Coordinate pandemic response between the ECC and ZEOC</li> <li>Work in collaboration with the Medical Director, Seniors Health in the event of a pandemic response</li> </ul>
<b>Medical Director, Seniors Health</b>	<ul style="list-style-type: none"> <li>Approve the Continuing Care Pandemic Operational Guide.</li> <li>Contact Zone EOC to initiate a pandemic response as identified by the ECC</li> <li>Coordinate pandemic response between the ECC and ZEOC</li> <li>Work in collaboration with the Director- Continuing Care Capacity, Funding and Workforce, Seniors Health in the event of a pandemic response</li> </ul>
<b>Communications</b>	<ul style="list-style-type: none"> <li>Work with identified stakeholders to develop a communication strategy in relation to a pandemic response to inform staff, clients, family and public</li> </ul>
<b>Human Resources (HR)</b>	<ul style="list-style-type: none"> <li>Supports the Zone(s) through the Zone EOC to deploy, redeploy and/or recruit as per the Human Resources Pandemic Plan</li> </ul>
<b>Emergency/Disaster Management</b>	<ul style="list-style-type: none"> <li>Ensures adequate AHS stockpile is established</li> <li>Coordinates distribution of equipment and supplies from AHS stockpile</li> </ul>
<b>Workplace Health &amp; Safety (WHS)</b>	<ul style="list-style-type: none"> <li>Provides confirmation of staff vaccination</li> <li>Supports Continuing Care programs and through preparation and pandemic response</li> </ul>

## **Appendix F: Care and Treat in Place Guidelines**

During a Pandemic Response, all sectors of the health care system will be challenged to meet the needs of clients.

- Continuing Care will continue to provide services to current clients' to maintain an appropriate level of care.
- Continuing Care will manage clients who develop Influenza-Like Illness and those who develop other medical conditions during a pandemic event in the client's current living environment except when acute episodic illness requires surgical intervention and/or other urgent acute care services.
- Decisions to discontinue admission to acute care will be informed by the Level of Activation as directed by the Emergency Operations Centre.

### Physician and Clinical Support

Zone Medical Directors and Zone Seniors Health are required to identify physician support in the event of a Pandemic Response.

Physicians are required to be accessible 24/7 (inclusive of telephone consultation).

- Physician coverage in Long Term Care is coordinated through the Zone Medical Director. The Zone Medical Director will disseminate information to all attending physicians.
- Physician coverage in Supportive Living will be determined by the Zone Medical Director and the ZEOC. The Zone Medical Director will disseminate information to all attending physicians.
- All staff are required to work to their full scope of practice to support Continuing Care clients.

### Guidelines for Care and Treat in Place:

The guidelines for Care and Treat in Place have been developed to support a pandemic response. These guidelines ensure that an appropriate level of care is maintained recognizing that usual service provision may *not* be maintained. These guidelines provide a framework to support service provision during a pandemic response:

- Care plans should inform service provision for all Continuing Care clients during a pandemic response.
- Clinical judgement must always inform service provision.
- Service provision will be dependent on the level of activation in a pandemic response.

NOTE: Changes may be made to the Care and Treat in Place Guidelines dependent upon the type of influenza requiring a pandemic response.



<b>Care and Treat in Place Plan</b>		
<p><b>Client exhibits symptoms consistent with Influenza Like Illness (ILI):</b> (acute onset of new cough or change in an existing Cough PLUS one or more of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt; or equal to 38 degree C)</li> <li>• Shortness of Breath, Sore throat, Dry cough</li> <li>• Joint pain</li> <li>• Muscle aches</li> <li>• Severe exhaustion</li> </ul>		
Assessment	Observations	Actions
Initial assessment by Health Care Professional (RN or LPN)	Vital signs stable	-General treatment of symptoms -Contact physician for early antiviral treatment -Medications as appropriate for symptom relief and comfort -Provide client and caregiver(s) flu self-care information/resources
Assessment by Health Care Professional (NP/RN/LPN)	Symptoms present: -Chest pain/ shortness of breath -Colored sputum -Night sweats, uncontrolled shivering -Nausea & vomiting (more than 3x in 24 hrs) -Diarrhea (more than 4x in 24 hours) -Syncope on standing or altered level of consciousness (LOC) -New confusion -Existence of other risk factors and/or co-morbidities	As above, and: -Arrange for further assessment by physician or NP as warranted by the clinical situation; If after hours, contact physician on call -Service provision informed by client's Care Plan
<p><b>Client has change in status requiring medical management for ILI and non ILI conditions (e.g. UTI, pneumonia, pyelonephritis)</b></p>		
Assessment by Health Care Professional (NP/RN/LPN)	Vital signs: -Pulse less than 50 BPM or greater than 110/BPM Respirations less than 10/min or greater than 24/min -Oxygen saturation less than 90% on room air, and cyanosis	-Arrange for urgent assessment by physician -Service provision informed by client's Care Plan -Before transport, the Physician or NP or Nursing Manager will determine availability of resources for transport and care. Transfer to acute care considered only for stabilization with early return to facility for ongoing care
<p><b>Client has symptoms of medical emergency</b></p>		
Initial assessment by Health Care Professional (RN or LPN)	Example: -Fracture -Head injury (altered LOC) -Acute myocardial infarction, stroke -Acute sepsis -Gastro intestinal bleed	-Arrange for urgent assessment by physician - Service provision informed by client's Care Plan -Triaged by EMS on scene and consultation with ED prior to transfer. Transfer to acute care considered only for stabilization (e.g. hip #, etc) with early return to facility for ongoing care

- Treatment of non-Influenza-Like Illness conditions and/ or medical emergencies will occur in the current environment (e.g. Continuing Care Designated Living Option); however, transfers to acute care may be necessary and will be considered based on the Level of Activation in Pandemic response.
- Some clients living in Supportive Living and Home Living environments may still retain their own family physician with which communication may be limited during a Pandemic response.
- During Pandemic response, there will be limited ability to provide diagnostic procedures (e.g. lab and X-ray) for clients with ILI and those with scheduled procedures.
- Assessment will be primarily based on observation and on-site examination.
- Should a client be admitted to Acute Care, Continuing Care must support the client as soon as the acute episode has been stabilized.

#### Infection Prevention and Control (as required)

- All AHS owned, operated and/ or contracted Continuing Care Service Providers are to perform a Point of Care Risk Assessment ([Form 3](#)) and wear N95 masks as required.  
***NOTE:** The cost of fit testing staff for N95 masks is the responsibility of the employer. In the event of a Pandemic, the masks may be provided.*
- Pre-exposure antiviral medication will be provided to Continuing Care staff and clients from antiviral stockpiles.

***NOTE:** Depending on the organism involved at the time of Pandemic and the clinical presentation of the client, specific adjustments may need to be made to resource materials.*

#### Management of Influenza

- When managing clients with ILI requiring oxygenation, hydration, antipyretics, and analgesics, it is expected whenever possible that:
  - Hypodermoclysis is the preferred practice for hydration therapy when professional nursing staff is available.
  - If IV therapy is required ([Form 8](#)), professional nursing staff will maintain the IV. IV initiation and maintenance will vary among zones dependant on resources and current practice including but not limited to IV/HPTP Teams, Home Care, mobile CNS or Nurse Practitioner staff, Emergency Departments, Emergency Management Services, etc.

## Appendix G: Surge Capacity Guidelines

### Guidelines for Organizational Identification of Surge Capacity

**During Pandemic response, available beds should be used as surge capacity.**

The addition of beds within surge capacity must comply with the following:

- Minimum of two (2) metres between clients.
- Availability of hand hygiene facilities at all points of care.
- Supplies for hand hygiene should include facility approved: plain liquid soap, single use towels, alcohol based hand rub and hand lotion.
- Sinks for hand hygiene should be used only for hand hygiene and not for other purposes.
- Separate space available for soiled and clean equipment and linens.

The addition of beds within surge capacity must consider the following:

- Availability of toilet and shower/bathing facilities near proximity (or a space for commodes).
- Carpeted areas are discouraged.
- Doorway size will accommodate bed and wheelchair access.
- Space for staff debriefing and family counselling.

**Equipment and supplies for a Pandemic response may include but are not limited to the following:**

<b>Suggested Equipment</b>			
Bed	Garbage can	O <sub>2</sub> regulators	Stethoscopes
Mattress	Mechanical lift	IV poles	Linens
Chair	Stretcher	Tables/chairs	Glucometer
Over-bed table	Portable suction	Medication cart	Pulse oximeter
Privacy divider	Suction meters	Lighting	Urinal/bedpan (disposable)
Commode	O <sub>2</sub> concentrators	Carts for storage	Basins- wash and K basins
Reclining chairs	O <sub>2</sub> flow meters	BP machines	Call bell system
Communication system (phone, computer)	Health record system (i.e chart, clipboard, kardex)	Access to water (hydration and for personal care)	Thermometer (disposable)
<b>Additional Med/Surg Supplies</b>			
Incontinence products	Dressing supplies	Alcohol based Hand Rub (ABHR)	WHMIS binder
Catheter supplies	IV/clysis supplies	Cleaning supplies	
PPE (gowns, gloves, eye protection, masks)	Personal care supplies (i.e. SAGE products)	Medical and biohazard disposal	

## **Appendix H: Surge Capacity Identification**

### **Surge Capacity in Supportive Living and Long Term Care**

Zones are required to identify surge capacity within the respective zone.

Surge Capacity is defined as additional bed based capacity identified and/or located within existing health care sites.

Zones are required to:

- Identify a surge capacity of 1-2 beds for every AHS owned, operated and/or contracted Supportive Living site and Long Term Care facility
- Spread the surge capacity beds across the geographical area of each Zone

In addition, Zones are required to identify the following to support a pandemic response:

- Zone
- Provider Legal name
- Facility/Program name
- Primary and alternate site contact for surge capacity (i.e.name, telephone number, fax number, email)
- Number of beds at site (Operational site capacity)
- Surge capacity (additional beds available)
- Limitations to surge space (e.g. no bathroom, no sink, etc.)
- Specific requirement(s) to increase surge capacity (i.e. items needed from stockpile including beds, lifts, etc.)

## Appendix I: Service Level Recommendations – Home Living

### Recommendations for Service Levels in Continuing Care based on Staffing Levels.

**Objective:**

Depending on available staffing in each facility, each site will likely be operating at a different service level. Areas of staff reassignment will be decided at the time of Pandemic depending on the local staffing picture.

***Decisions to reduce, suspend or enhance services should be made based on nursing / professional judgment, client needs, Infection Prevention and Control Guidelines, direction from Public Health and AHS Emergency Coordination Centre and the Zone Emergency Operations Centre. Ability to ensure clients are cared for in a safe manner should be foundational to such decision-making.***

### Home Living

Notes on Staffing Model for Home Living:

1. ALL staff should be expected to work to full scope of practice
2. Decant staff – utilize casual and float positions to maximum

Home Living Services	Services when staffing ↓10-20%	Services when staffing ↓20-30%	Services when staffing ↓30% +	Surge Capacity (if staffing permits)
<b>Priority</b>	Clients maintained in their homes.	Maximize existing clinics and have clients there when possible.  Provide necessary and essential visits only – Influenza-like Illness (ILI) Services in the Home Encounters – Screening Tool ( <a href="#">Form 2</a> ).  Implement telephone ‘visits’ where able.	Essential visits only – telephone screening prior to visit to assess for ILI.  Maximize telephone visits.  Decant staff throughout the Home Care Program.	To care for early discharges from acute care or temporary transfers home from Facility or Supportive Living.

		<p>Mobilize family assistance for care provision where possible.</p> <p>Cancel Adult Day Support Programs.</p> <p>Ensure staff wears Personal Protective Equipment.</p> <p>Decant staff to other teams in need (if possible).</p>		
<b>Strategy</b>	<ol style="list-style-type: none"> <li>1. Decant staff to other teams if necessary to assist with vaccinations and/or providing care.</li> <li>2. Clients should have a disaster plan in place or develop alternatives when necessary.</li> <li>3. Decant staff to other teams if necessary to assist with vaccinations and/or providing care.</li> </ol>			
<b>Comments:</b>	<p>May need to prioritize clients – identify which clients need essential visits for interventions such as specific medications (insulin, lasix, IV therapy), wound care, personal care that may put client at risk of hospitalization such as catheterization &amp; immobility, lives alone</p> <p>Use Home Care screening prior to visit for ILI</p>			

**Appendix I: Service Level Recommendations – Supportive Living**
**Recommendations for Service Levels in Continuing Care based on Staffing Levels.**
**Supportive Living**

Due to their generally smaller size and staff numbers, Supportive Living sites may be impacted more severely by reduced staffing levels. The larger supportive living sites may be able to operate similar to Facility-Living (as per the next section). The smaller sites may have to take compensatory action earlier as below.

<b>Supportive Living:</b> <b>Services when staffing ↓10-20%</b>	<b>Services when staffing ↓20-30%</b>	<b>Services when staffing ↓30% +</b>	<b>Surge Capacity (if staffing permits)</b>	<b>Notes on Staffing Model</b>
Clients maintained on site. Medications and medically necessary care. Focus on care basics – routine toileting and incontinence care; assistance with feeding; some limited bathing / showering; nail and foot care deferred except for diabetics. Clothing and bedding changed only as needed. Cancel social / leisure programming (enhanced programming for dementia clients to be maintained). Reschedule non-urgent appointments. Redeploy site staff to assist as needed. Mobilize volunteer / family assistance for care provision. Evaluate clients for feasibility of being discharged temporarily to home with family or home with Home Care (if Home Care capacity allows).	Temporarily discharge clients home with family, home with Home Care (if Home Care capacity allows), or consolidate at other congregate setting.  For remaining on-site residents, provide medications and medically necessary treatments; strategies for basic feeding, toileting, and hygiene.	Temporarily discharge clients home with family, home with Home Care (if Home Care capacity allows), or consolidate at other congregate setting.  For remaining on-site residents, provide medications and medically necessary treatments; strategies for basic feeding, toileting, and hygiene.	To care for admissions from acute care or home-living clients not able to be managed in the home.  Consider utilizing spaces freed up by clients able to be cared for in alternate setting (family or Home Care).	Full scope of practice by all staff when staffing levels and staff mix permit.  May need to consider basic functional nursing models where many redeployed staff or volunteers are assisting.

**Appendix I: Service Level Recommendations – Long Term Care**

**Recommendations for Service Levels in Continuing Care based on Staffing Levels.**

**Long Term Care**

<b>Facility Living: Services when staffing ↓10-20%</b>	<b>Services when staffing ↓20-30%</b>	<b>Services when staffing ↓30% +</b>	<b>Surge Capacity (if staffing permits)</b>	<b>Notes on Staffing Model</b>
<p>Clients maintained on site.</p> <p>As much as possible, focus on 'care as usual' - medical and nursing plan of care, personal care, laundry, housekeeping, social/leisure programming.</p> <p>Re-deploy site staff to assist as needed.</p>	<p>Clients maintained on site.</p> <p>Medications and medically necessary care.</p> <p>Focus on care basics – routine toileting and incontinence care; assistance with feeding; some limited bathing / showering; nail and foot care deferred except for diabetics.</p> <p>Clothing and bedding changed only as needed.</p> <p>Cancel social / leisure programming (enhanced programming for dementia clients to be maintained).</p> <p>Reschedule non-urgent medical appointments.</p> <p>Cancel facility respite.</p> <p>Mobilize volunteer / family assistance for care provision.</p> <p>Evaluate clients for feasibility of being discharged temporarily to home with family or home with Home Care (if Home Care capacity allows).</p>	<p>Temporarily discharge clients home with family, home with Home Care (if Home Care capacity allows), or consolidate at other congregate setting.</p> <p>For remaining on-site residents, provide medications and medically necessary treatments; strategies for basic feeding, toileting, and hygiene.</p>	<p>To care for admissions from acute care or home-living clients not able to be managed in the home.</p> <p>Consider utilizing spaces freed up by clients able to be cared for in alternate setting (Family or Home Care).</p>	



**Appendix J: Communicating with Continuing Care Service Providers**

## Template for Zone Use

Each Zone must develop a process for communicating with AHS owned, operated and or Contracted Continuing Care Service Providers. Zones should consider the following information to identify resources and capacity to support a pandemic response:

- Zone
- Operator name
- Facility name
- Site capacity (beds)
- Staff list (if AHS owned and operated site/ program)
- Primary and alternate site contact
- Address
- Phone number, fax number and e-mail address

## Appendix K: Staffing Levels and Use of Volunteers

### Staffing Background

Current staffing levels in Continuing Care vary according to service provision, funding, staffing models, type of program or facility, size of the program or facility, shift, and the location of the facility (urban or rural).

Generally, the staffing supports models for Continuing Care:

- Long Term Care: RN 24 hrs/day with LPN, HCA and limited Allied Health professional service. Long Term Care sites have 1 RN for every 50 to 100 clients on days and evenings, with primarily just 1 RN in the building on a night shift. This is variable. Health Care Aide (HCA) staff would be present in a ratio of about 1 to 10 clients on days and evenings and 1 to 20 or 1-25 on nights.
- Supportive Living 4 and 4D: 24-hour LPN coverage and 24-hour HCA support with RN on-call availability.

**Note:** *These staffing numbers are very streamlined and, considering the care that is provided at these sites, it will be difficult to decrease the number of staff in a facility given that the implementation of Care and Treat in Place will increase the acuity and complexity of the clients.*

Pandemic response will place increased demands on staff to maintain Care and Treat in Place Guidelines. Staff absence due to illness must also be considered.

Consideration of the following is essential to planning for a pandemic response:

- Client and staff safety.
  - Infection prevention and control guidelines.
  - Availability and utilization of professional staff (i.e. staff could be shared between units in same building, available on an on-call basis, etc.)
  - Availability of staff and others (i.e. deployed staff, family and volunteers) to maintain an appropriate level of care.
  - Emphasis on the provision of appropriate care and medically necessary treatments.
- Protocol for influenza immunization is followed as per workplace health and safety guidelines located:
    - AHS: <https://insite.albertahealthservices.ca/Main/assets/hr/tms-hr-whs-influenza-outbreak-management.pdf#search=whs%20outbreak%20information>
    - Continuing Care Connection: [connection.ahs.ca](https://connection.ahs.ca)

### Recruiting Additional Staff:

Additional staff will be required at sites to support a pandemic response. Resources will need to be coordinated between sites through the ZEOC with the assistance of operational leadership. Increased professional care (i.e. RN) will be required as the level of activation increases.

Increased acuity and complexity of clients will necessitate an increase of staff to maintain basic care.

Human Resources assistance will be required to develop staffing strategies surrounding the use of volunteers and the deployment of staff from other areas to front line care.

These issues are especially challenging for private and voluntary Continuing Care providers, as they do not have the benefit of a consistent Human Resources plan. Industry associations such as the Alberta Continuing Care Association (ACCA) Alberta Senior Citizen Housing Association (ASCHA) and others could be used as a resource in this area for the voluntary and private providers.

### **Use of Volunteers**

In a pandemic response, volunteers may need to be utilized to provide client care. When initiating a volunteer during pandemic response, Continuing Care will maintain compliance with:

- Provincial legislation regarding criminal record checks unless otherwise directed by Provincial Pandemic Operations
- Increased use of Statutory Declarations may be necessary if the ability to get a Criminal Record Check during a pandemic response is reduced or delayed

To prepare for use of volunteers, orientation may be required to ensure competency. Orientation should include:

#### **Basic personal care**

- Observation of client status
- Oxygen administration
- Skin care
- Toileting and incontinence care
- Positioning, ambulation & mobilization
- Feeding/hydration

#### **Infection Prevention and Control**

- Respiratory etiquette
- Influenza precautions
- Environmental cleaning

#### **Non Care related functions**

- Records management
- Food preparation
- Security
- Protection for Personal In Care (PPIC)

Comfort Care - Level 1 skills training module is available at:

- Insite: <https://insite.albertahealthservices.ca/main/assets/tms/hpsp/tms-hpsp-mod-level1-comfort-care.pdf>
- Continuing Care Connection: [connection.ahs.ca](https://connection.ahs.ca)

**Appendix L: Quarantine Protocol - Patient Care Based Funding****Outbreak Rules**

1. New admissions will be allowed during outbreak if submitted. Residents admitted during outbreak will remain in the BC2\* (see explanation below) category until after the outbreak period. If the outbreak is less than 60 days, residents will drop to BC1\* category 2 days after the outbreak period end date, if no assessments are submitted. If the outbreak length is greater than or equal to 60 days, residents will drop to a BC1 category 14 days after the outbreak period end date if no assessments are submitted.
2. No discharges will be processed during the outbreak period. If the outbreak length is less than 60 days, any discharges that occur within the outbreak period will be processed 2 days after the outbreak period end date. If the outbreak length is greater than or equal to 60 days, any discharges that occur within the outbreak period will be processed 14 days after the outbreak period end date.
3. New admissions that occur less than 16 days before outbreak start date or during the outbreak period will not drop to a BC1 category after 15 days during the outbreak period. New residents will continue to be funded at the BC2 category level until the outbreak period end date. If the outbreak length is less than 60 days, residents will drop to a BC1 category 2 days after the outbreak period end date if no assessments are submitted. If the outbreak length is greater than or equal to 60 days, residents will drop to a BC1 category 14 days after the outbreak period end date if no assessments are submitted.
4. Rule 2 under the “Additional Business Data Rules” section will be disabled during outbreak. This means residents will not drop to a BC1 category after 100 days between assessments. If the outbreak length is less than 60 days, Residents will drop to a BC1 category 2 days after the outbreak period end date if no assessments are submitted. If the outbreak length is greater than or equal to 60 days, Residents will drop to a BC1 category 14 days after the outbreak period end date if no assessments are submitted.
5. Facility average Case Mix Index (CMI)\* will be frozen at the level of the day before outbreak start date. New admissions received during an outbreak period may affect the average CMI.

\*Note: The outbreak procedure currently in place to ensure the maintenance of funding levels during outbreaks in LTC. BC2 refers to a high CMI funding category received by each resident for 15 days upon admission. BC1 is a lower Case Mix Index (CMI) category typically granted to residents whose assessments have expired, or where no assessment has been submitted. For further information/clarification on Patient Care Based Funding contact your zone representative.

For further information/clarification on Patient/Care-Based Funding (PCBF), please contact your zone representative or Fahd Mirza ([fahd.mirza@ahs.ca](mailto:fahd.mirza@ahs.ca) or 780-735-0096).

**Appendix M: Contingency Planning****Responsibilities for Continuing Care Service Providers****Background, Applicability and Assumptions**

In the event of Pandemic, it is assumed that Continuing Care facilities will manage clients within their facility or program without transferring them to an acute care setting (except in case of acute episodic illness requiring surgical intervention or other urgent acute care urgent services). This includes clients with Influenza-Like Illness (ILI).

[See printable Contingency Tracking form \(Form 5\)](#)

**Guidelines**

Pandemic is an unpredictable disaster which will evolve over an extended period of time. Organizational plans must be both flexible and responsive to the changing nature of the disease itself and should consider the following:

1. Responsibility for the development and ongoing review of disaster planning, including Site Leader Medical role (where applicable) and administrative accountability
2. Establishment of responsibility, authority structure, and communication plan in the event of an infectious disease disaster
3. Maintenance of ongoing staff competency in Infection Prevention and Control and Outbreak Management
4. Maintenance of ongoing influenza prevention and management strategies
5. Maintenance of supplies
6. Contingency for staffing capacity
7. Management of Occupational Health and Safety requirements including site responsibility to ensure N95 fit testing
8. Determination of care delivery plan for individuals who acquire Pandemic
9. Determination of process to manage the deceased

**Appendix N: Temporary Discharge to Community During Service Interruption  
(Family and/or Informal Caregiver)**

In the event of a pandemic response, family and/or informal caregivers may be required to support Continuing Care clients.

Programs and/or sites should consider the following when identifying likelihood of temporary discharge from a Continuing Care program.

***Family and/or informal caregivers should be asked “In the event of a service interruption do you have the ability to provide care for your loved one?”***

Sites/Programs should consider documenting:

- Client Name
- Family and/or informal caregiver contact
  - Name
  - Telephone number
  - Email address
- Special considerations (e.g. wandering, dialysis)

## **Appendix O: Changes to Normal Operating Procedures**

Normal processes and procedures will be followed whenever possible. Changes to normal operating processes are noted below:

### **Admission Process & Guidelines:**

- During a pandemic response, specific information regarding the restriction of **new admissions, re-admissions and resident accommodation will be determined by the Medical Officer of Health (MOH) in collaboration with Seniors Health.**
- Sites may be asked to accept clients during a pandemic response. **AHS owned, operated and/or contracted Supportive Living and Long Term Care facilities will be required to provide surge capacity.** Surge capacity may be used to support Home Care clients requiring more intensive care and/or clients decanted from acute care.

### **Coordinated Access / Transition Services:**

- During pandemic response, clients will be decanted from acute care. **Waitlist management procedures will be suspended and facilities with available beds will be used to decant Alternate Level of Care (ALC) clients.**
- There will be increased demands on Coordinated Access throughout the pandemic response including during the Recovery and Resumption Levels of Activation.
- During the Recovery and Resumption Level of Activation, usual operating waitlist management procedures will resume. Alternate Level of Care clients, will be assessed for their appropriate level of care and prioritized for transfer to the appropriate setting.
- During the Recover and Resumption Level of Activation, Coordinated Access services in each Zone will work with the EOC and site command posts to track the location of clients.

### **Home Care:**

- During the Recovery and Resumption Level of Activation, Home Care services will resume to usual operational practice based on staff availability to meet the client's assessed need.

### **Overcapacity in Response to Surge Numbers:**

- Zones may consider deployment of staff from other areas to maintain a basic level of care for Continuing Care clients. Alternative sites will only be considered if in-situ staffing cannot maintain an appropriate level of care. Human Resource (HR) will assist in the deployment of staff, the management of staff, or other arising issues related to HR.
- Alternative Care Centres (ACC) will be established to provide additional capacity as required within Zone(s).

### **Clinical Treatment Guidelines:**

- During a pandemic response, Continuing Care facilities will be required to enhance care in place rather than sending residents to acute care hospitals except when acute episodic illness requires surgical intervention and/or other urgent acute care services. (See *Care and Treat in Place Guidelines* [Appendix F](#)).

**Pharmacy:**

- Continuing Care has access to pharmacy services provided by AHS, community pharmacies and site based pharmacies.
- A clearly defined communication plan must be established with all Continuing Care pharmacy providers to ensure continuous service is maintained during the pandemic.
- Pharmacy providers should have approximately a one (1) month supply of the most commonly prescribed medications. Less commonly prescribed medications must be readily available in the local wholesales.
- AHS pharmacy services maintain lists of medications required for pandemic response.
- Continuing Care must establish a plan with pharmacies to determine the type and quantity of essential medication stockpiles based on site specific utilization patterns.

**Documentation:**

- During pandemic response, documentation of client status is required; however, content will be brief to ensure resources are available to maintain an appropriate level of care.
- During increased Levels of Activation, a visual or bedside care plan will be in place for all clients to assist staff in maintaining basic care ([Form 10](#)). This plan will summarize Activities of Daily Living (ADLs), and Basic Disaster Life Support (BDL's) required for the client ([Appendix I- Home Living](#); [Supportive Living](#); [Long Term Care](#)).

**Infection Prevention & Control (IP & C):**

- Prevention measures for the transmission of the pandemic strain will be applied. Sites will activate their IPC outbreak protocol during pandemic response.
- Current AHS outbreak processes will be used for enhanced daily and terminal cleaning of client spaces and equipment.

**Care Planning:**

- Clients decanted to Continuing Care sites require a Care Plan to be sent with them. Care Plans must be reviewed by the receiving site at this time.
- A Visual Care Plan ([Form 10](#)) may be used depending on the level of activation.
- If the client does not have a Goals of Care Designation Order upon admission, the client shall be treated as an R1 (Resuscitative) Designation until their goals of care order can be reassessed by a physician.
- Code procedures vary from site to site and must be reviewed with attention to current pandemic activation status, and care and treat in place. Unless otherwise directed by the Zone Emergency Operations Centre (ZEOC), facilities will use the normal process for



emergency response, recognizing EMS will use a specific triage process upon Pandemic activation.

**Safety and Security:**

- Protection from theft and vandalism will be a high priority due to the potential of limited supplies and equipment and potential supply chain interruption.
- Consideration of security staff is necessary. Continuing Care sites do not have security staff on site. Sites may consider strategies included but not limited to the use of lock down or hiring outside agencies. Consultation with HR is required.

**Visitor Policy:**

- General visiting will be limited and managed in accordance with AHS protocol and will be further restricted under the direction of ZEOC.
- Visitors attending Continuing Care sites to assist in providing client care will be subject to all Infection Prevention and Control measures.

**Disposal and Holding of Bodies:**

- There is no additional risk of influenza transmission to workers handling the bodies of those confirmed to have influenza.
- Most Continuing Care sites do not have body holding areas. Continuing Care sites need to consider locations for body holding areas. Zones need to establish relationships with local funeral homes and develop a contingency plan for alternative holding space (eg. ice rink, refrigerated truck, etc.).
- Continuing Care sites are required to establish processes for corpse management including supplies, transportation, and storage.
- Continuing Care sites are required to be culturally and religiously aware when handling deceased bodies.
- See Public Health Agency of Canada Guidelines for the Management of Mass Fatalities During an Influenza Pandemic (<http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-i-eng.php>).

**Form 1: Sample Surge Capacity Spreadsheet**

Zone									
Provider Legal Name	Facility/Program Name	Number of beds at site (Operational site capacity)	Surge Capacity (additional beds available)	Limitations to Surge Space	Specific Requirement(s) to increase Surge Capacity	Primary Contact		Alternate Contact	
						Name		Name	
						Telephone		Telephone	
						Fax		Fax	
						email		email	
						Name		Name	
						Telephone		Telephone	
						Fax		Fax	
						email		email	
						Name		Name	
						Telephone		Telephone	
						Fax		Fax	
						email		email	
						Name		Name	
						Telephone		Telephone	
						Fax		Fax	
						email		email	
						Name		Name	
						Telephone		Telephone	
						Fax		Fax	
						email		email	



Form 2: Influenza-like Illness (ILI) Services in the Home Encounters – Screening Tool

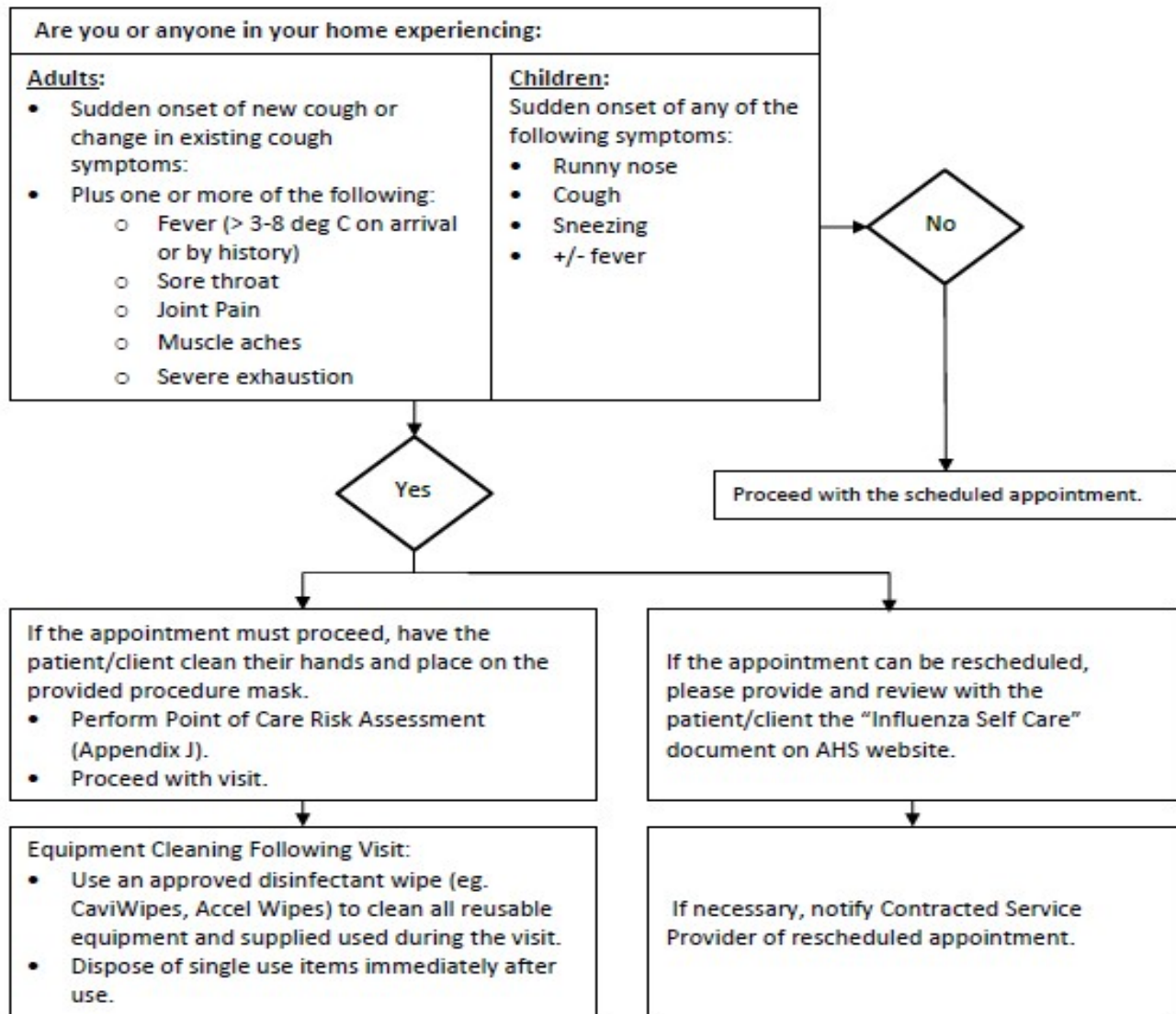


**INFLUENZA-LIKE ILLNESS (ILI)**

**SERVICES IN THE HOME ENCOUNTERS – SCREENING TOOL**

Conduct an assessment by phone of all clients and others residing in the residence before proceeding with any scheduled appointments. If not possible to conduct the assessment by phone, it must be completed upon arrival at the home.

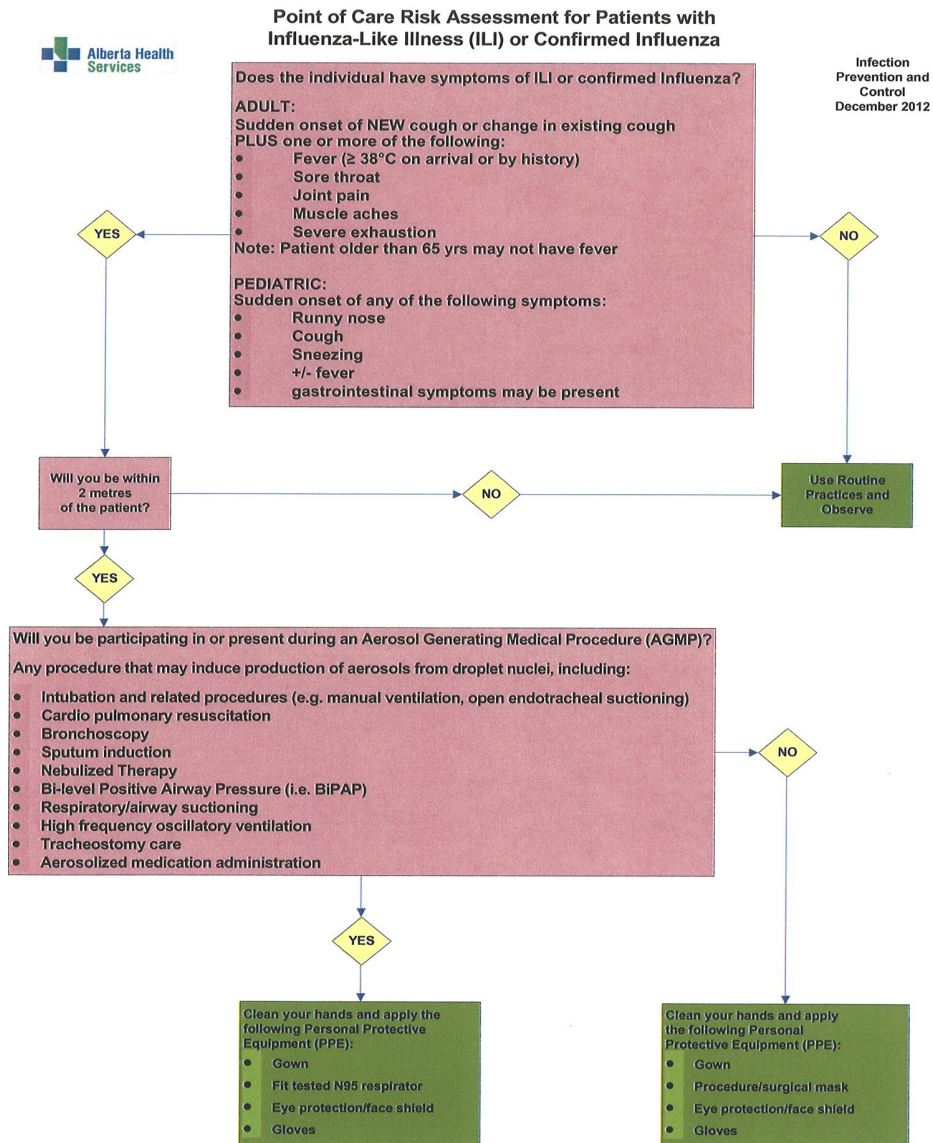
Use the following algorithm, based on the Influenza-Like Illness screening criteria, for the initial assessment and to determine the appropriateness of the scheduled visit.



Reproduced by AHS Seniors Health Provincial Strategy Team  
 Originally From: AHS Infection Prevention and Control  
 File Name: ILI Services in the Home Encounters-Screening Tool (October 26, 2009)

**Printable Copy Available at:**

<https://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ipc-respiratory-additional-precautions-assessment.pdf>





### Form 4: Infection Prevention and Control – Sample Tracking Form/Template

Zone: Case #1 Case #2 Case #3 Case #4 Case #5 Case #6

Zone:		Case #1	Case #2	Case #3	Case #4	Case #5	Case #6	El#: OB#:	
Demographics	Onset Date(yyyy/mmm/dd)							List For: <input type="checkbox"/> Residents/Clients <input type="checkbox"/> Staff	
	Last Name							Facility:	
	First Name							Unit:	
	PHN #							Unit Phone #:	
	Room #							Unit Fax #:	
	Age								
	Sex								
Symptoms	<b>Day 0 (Onset)</b>							IPC Contact:	
	<b>Day 1</b>							Phone #:	
	<b>Day 2</b>							Fax:	
	<b>Day 3</b>							# of Residents: Unit Facility	
	<b>Day 4</b>							# of Staff: Unit Facility	
	<b>Day 5</b>								
	<b>Day 6</b>								
	<b>Day 7</b>								
	<b>Day 8</b>								
Other	Comments							<p align="center"><b>Symptoms Legend</b></p> <p>C - New Cough  ST - Sore Throat  MA -Muscle Aches  F - Fever  E - Exhaustion  JA - Joint Aches  P - Pneumonia by xRay  V/D -Vomiting/Diarrhea  HO - Hospitalized due to ILI  DE - Deceased due to ILI  O - Other (use comments area)  NS - No Symptoms</p>	
Lab Tests	NP Swab (yyyy/mmm/dd)							Please record "NS" for 5 days from onset date or until outbreak declared over.	
	NP Swab results								
	Throat Swab (yyyy/mmm/dd)								
	Throat Swab result								
Vaccinations	Influenza (yyyy/mmm)							<p align="center"><b>Fax to Zone Public Health Office</b></p> <p>Regular Hours: After Hours:</p>	
	Pneumococcal (yyyy/mmm)								
Antiviral	Amantadine (yyyy/mmm/dd)								
	Oseltamivir (yyyy/mmm/dd)								

Adapted from Provincial Outbreak Management Protocol January 2010

**Form 5: Pandemic Contingency Planning**

**Pandemic Contingency Planning**

**Responsibilities for Continuing Care Service Providers:**

- Maintain high levels of surveillance for increases in respiratory or other infectious illness
- Maintain processes for appropriate response to outbreaks of respiratory or other infectious illness
- To initiate the development of Pandemic Planning
- To integrate Pandemic planning into organizational disaster planning

Specific Action	Strategies	Responsibility	Status
Ensure competency for Infection Prevention and Control (IPC) and Outbreak Management	Ensure all staff familiar with appropriate IPC practices based on current Infection Control Guidelines including Respiratory Hygiene, Use of Personal Protective Equipment, Hand Hygiene etc.		
	Ensure all staff aware of outbreak procedures based on current Outbreak Manual including communication processes.		
Maintain Influenza Prevention & Management Strategies	Continue to vaccinate (Influenza and Pneumococcal where appropriate) high percentage of staff and residents.		
	Facilitate staff and visitors to stay home when ill.		
	Ensure readiness to rapidly implement influenza vaccination of residents & staff & antiviral prophylaxis &/or treatment for influenza outbreaks.		
Support AHS Surveillance Activities	Report Influenza-like Illness or other infectious illness cases as per Outbreak Guidelines.		
	Participate in AHS communication processes as requested.		
	Monitor staff absenteeism.		
Establish Responsibility for Emergency Disaster Preparedness Plan which includes Pandemic Readiness Plan	Define role of Facility Administrative and Medical Director (where applicable) in alignment with AHS Pandemic Plan and Outbreak Procedures.		
	Determine under what authority the Facility Pandemic Plan is implemented, in alignment with AHS Plan.		
	Identify the facility EOC/ECC specific to infectious disease disaster		
Build Contingency for Staffing Capacity	Plan for training for additional responsibilities of staff and for potential non-availability of professional staff		



## Pandemic Contingency Planning

### Responsibilities for Continuing Care Service Providers:

- Maintain high levels of surveillance for increases in respiratory or other infectious illness
- Maintain processes for appropriate response to outbreaks of respiratory or other infectious illness
- To initiate the development of Pandemic Planning
- To integrate Pandemic planning into organizational disaster planning

Specific Action	Strategies	Responsibility	Status
	Plan for possible training of volunteers and family as care givers in event of reduced staff or surge capacity.		
	Build in orientation process for personal disaster preparedness in pandemic educational programs.		
	As part of any Emergency Preparedness plan for backup of all functions including maintenance, housekeeping, food services, etc.		
Manage Occupational Health Requirements	Plan to protect staff from respiratory and other infectious diseases N95 mask fit testing, vaccination, etc.		
	Education of staff including training on IPC and prevention		
	Determine equipment needs for staff protection, (e.g. isolation gowns, gloves, masks, hand hygiene, eye protection, etc.)		
	Determine need for extra supplies on site and process for rapid acquisition of additional supplies.		
	Determine capacity for handling increased waste (due to increased use of PPE and supplies).		
Determine care delivery in event of reduced staffing or surge capacity	Identify essential services and establish contingency plans to maximize efficiency of care delivery (space and staff). Contingency Plans should recognize the potential for different surge situations requiring different levels of response and the potential for using alternative models of care during such situations.		
Determine plan for care of residents ill with pandemic.	Develop inventory of space, equipment & supplies – (e.g. pulse oximetry, IV, hypodermoclysis, O <sub>2</sub> , congregate care spaces, gowns, and masks) as applicable to care setting.		

## Pandemic Contingency Planning

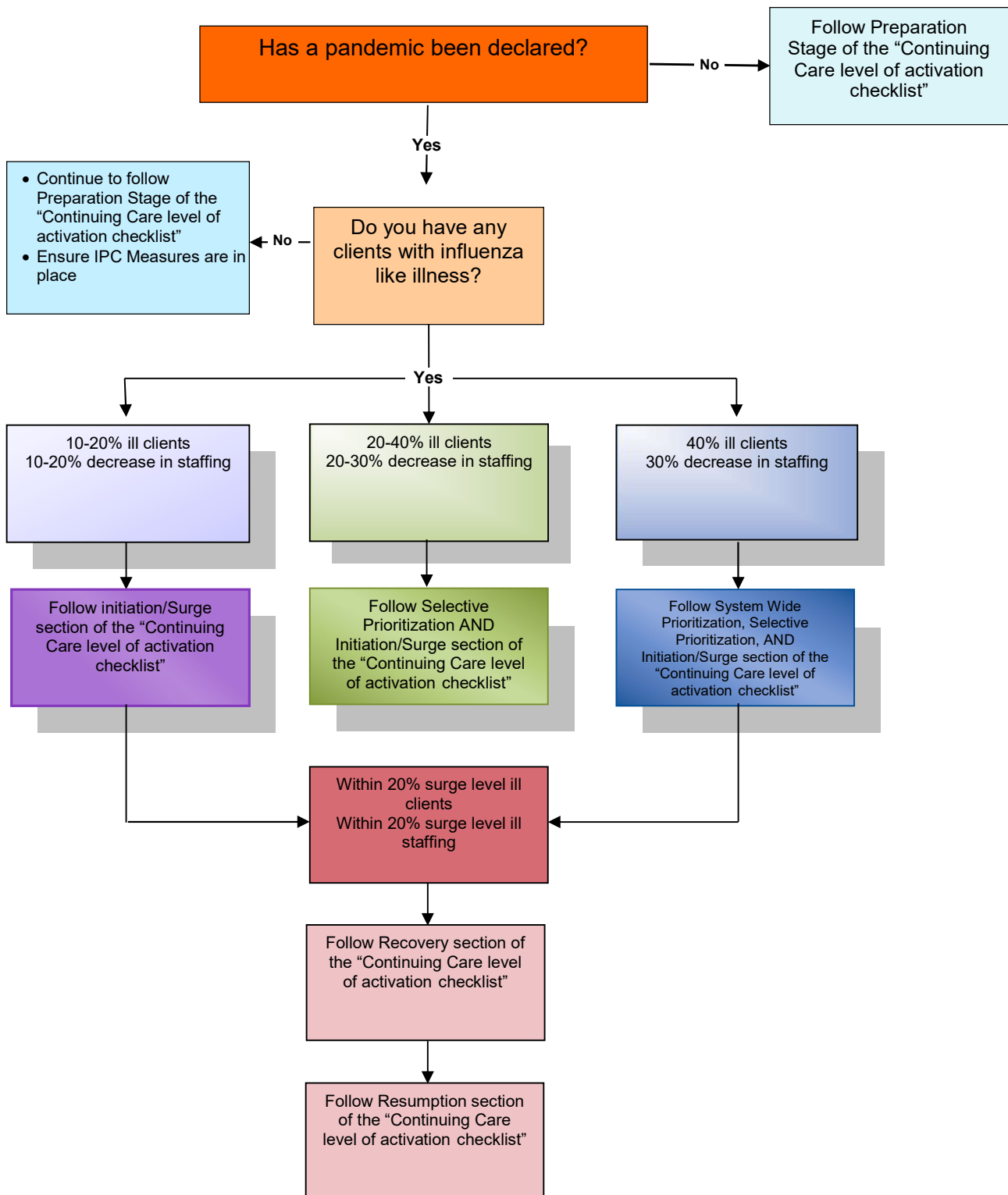
### Responsibilities for Continuing Care Service Providers:

- Maintain high levels of surveillance for increases in respiratory or other infectious illness
- Maintain processes for appropriate response to outbreaks of respiratory or other infectious illness
- To initiate the development of Pandemic Planning
- To integrate Pandemic planning into organizational disaster planning

Specific Action	Strategies	Responsibility	Status
	Develop processes for timely diagnosis and management of pandemic/infectious disease in residents. Utilize available protocols.		
	For sites with regular medical coverage, determine medical staff coverage in alignment with site or zone Pandemic Plan		
	Determine pharmacy support needs and access during Pandemic Outbreak.		
Establish Communication Plan during Pandemic/Infectious Disease Outbreak	Determine plan for communicating with staff, residents, clients, families.		
	Identify processes for documentation related to Pandemic, including tracking of pandemic related expenses.		
Determine Criteria for Transfer of Residents to Acute Care during Pandemic	Follow directions for care of non-pandemic acute illness, pandemic illness in selected populations, staffing inadequacies/crises, etc. in alignment with AHS Pandemic Plan.		
Determine process for Management of Deceased	Use regular processes of site. Determine contingency for short term body storage if necessary.		
Determine Post Pandemic/Unusual Infectious Disease Outbreak Needs	Document service provided, staffing, medical coverage, supplies, etc.		
	Participate in debriefing with applicable pandemic group following outbreak.		



## Form 6: Continuing Care Operators - Level of Activation Algorithm



## Form 7: Level of Activation Checklist - Continuing Care Operators

### **Level: Preparation**

*Current patient volume, current staffing levels, current functional capacity*

- Review and update site specific pandemic response Plan
- Attend and participate in any AHS Pandemic Response Plan information sessions.
- Review and update fan out lists
- Educate staff on pandemic response Plan
- Review and update Outbreak Management documents
- Review and educate staff on safe care practices and respiratory etiquette for Influenza Like Illness
- Promote and facilitate annual influenza vaccination for staff and clients
- Review site strategy plan to maximize capacity
- Review and update pandemic response plan to address staffing declines
- Identify sites for zone surge capacity
- Review information, forms and process for tracking clients
- Review information, forms and process for tracking human resources
- Review information, forms and process for equipment and supplies
- Review Service Level Recommendations guidelines for your area
- Participate in a tabletop pandemic exercise, as appropriate.

### **Level: Initiation/Surge**

*10-20% of clients are ill, 10-20% decrease in staffing levels, 10-20% decrease in functional capacity*

- Establish facility/site command post as necessary
- Initiate Care and Treat in Place plan ([Appendix F](#))
- Activate enhanced surveillance tracking per IPC Outbreak Guidelines ([Form 4](#))
- Initiate visitor policy as per IPC Outbreak Guidelines
- Implement and schedule IPC skills and respiratory etiquette/routine practices and additional precautions
- Initiate plan for Just in Time Training – Comfort Care Level One ([Appendix K](#)) of Pandemic Relief workers/volunteers
- Prepare visual care plans for bedside use
- Identify clients to be discharged to community and identify community supports ([Appendix N](#))
- Communicate any changes to normal operating procedures as needed
- Initiate antiviral administration program
- Follow direction of the ZEOC

### **Level: Selective prioritization**

*20-40% of clients are ill, 20-30% decrease in staffing levels, 20-30% decrease in functional capacity*

- Facility/site discharge coordination group
- Prepare for Pandemic relief workers/volunteers.
- Ensure that appropriate training of Pandemic relief workers/ volunteers has been completed
- Activate enhanced occupation health surveillance
- Implement business recover and resumption plans and task list

**Level: System wide prioritization**

*40% or more clients are ill, 30% decrease in staffing levels, 30% decrease in functional capacity*

- Review daily reports being sent to the ZEOC
- Adjust staffing model as needed ([Appendix K](#))
- Sustain business recover and resumption plan.

**Level: Recovery**

*Within 20% of surge level ill clients, within 20% surge level staffing, within 20% surge level functional capacity.*

- Implement phased approach to resumption of pre-pandemic services.
- Implement formal staff/ volunteer recognition program

**Level: Resumption**

*Activities occur within 6 months of initial activation*

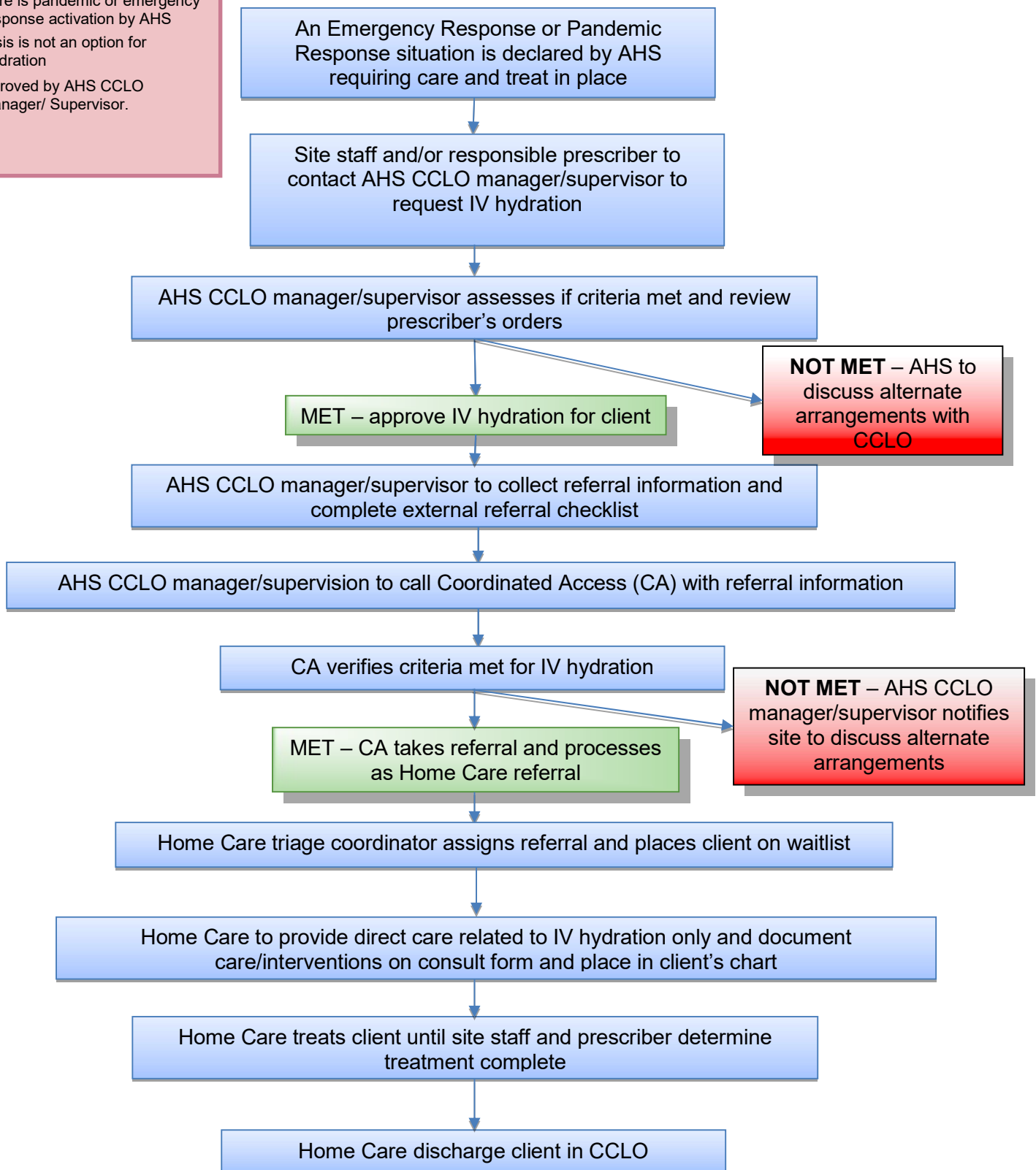
- Completion of Evaluation/Audit reports
- Review and revise Pandemic Plan.

## Form 8: Pandemic Response IV Hydration for Continuing Care Clients

### Emergency/Pandemic Response IV Hydration for Continuing Care Living Options (CCLO)

#### CRITERIA for IV Hydration:

- \*There is pandemic or emergency response activation by AHS
- \*Clysis is not an option for Hydration
- \*Approved by AHS CCLO Manager/ Supervisor.



**Form 9: SAMPLE External Referral Form**



**Emergency/Pandemic Response**  
**External Referral Checklist for IV Hydration**

Client Name: \_\_\_\_\_ Client Address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Suite Number: \_\_\_\_\_  
PHN: \_\_\_\_\_ Client Phone #: \_\_\_\_\_

**Program Type:**

- Integrated Supportive Living (ISL)
- Integrated Facility Living (IFL)

Site Name: \_\_\_\_\_  
Site Contact: \_\_\_\_\_

After-hours contact name & phone #: \_\_\_\_\_

**Priority of Order**

- 2 – 4 Hours
- Same Day

**IV tubing available at site?**

- Yes
- No

**What services are required?**

- IV Start
- IV Monitoring
- IV Discontinue

**IV solution available at site per order?**

- Yes – What type? \_\_\_\_\_
- No

Location of signed prescriber order: \_\_\_\_\_  
Please fax order to: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber contact info: \_\_\_\_\_

Guardian/Alternative Decision Maker: \_\_\_\_\_

Next of Kin: \_\_\_\_\_

Reason for Order for IV Hydration: \_\_\_\_\_

Reason that clysis was not an option: \_\_\_\_\_

Reason for Care & Treat in Place: \_\_\_\_\_

Medical History:

Safety Concerns:

Supplies required for IV Hydration:

(Note that IHL will provide IV Start supplies)

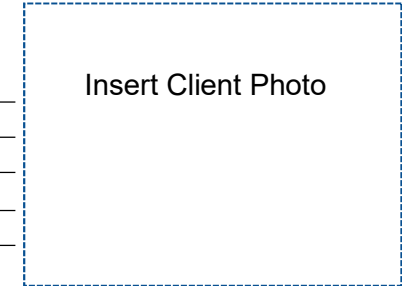


### Visual Care Plan (Sample Only)















Resident Name: \_\_\_\_\_  
 Room Number: \_\_\_\_\_  
**ALLERGIES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Diet: \_\_\_\_\_

Special Care: \_\_\_\_\_  
Eg. Positioning Requirements  
 \_\_\_\_\_  
 \_\_\_\_\_



Oxygen:  No  Yes- Rate: \_\_\_\_\_

<b>Dressing</b> 	<b>Washing</b> 	<b>Feeding</b> Self <input type="checkbox"/> Assist <input type="checkbox"/> Adaptive Utensils Yes <input type="checkbox"/> No <input type="checkbox"/> Nosey Cup Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Mobility</b> <b>Walker</b> No <input type="checkbox"/> 4ww <input type="checkbox"/> 2ww <input type="checkbox"/> <b>Wheelchair</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Geri-chair</b> <input type="checkbox"/> Turn q2h & prn <input type="checkbox"/>		<b>Transferring</b> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Min. Assist <input type="checkbox"/> 1 PA <input type="checkbox"/> 2 PA <input type="checkbox"/> Sit-Stand <input type="checkbox"/> Mechanical <input type="checkbox"/>	
<b>Compression Therapy</b> <b>Pressure Gradient Stocking (PGS)</b> Above Knee <input type="checkbox"/> Below Knee <input type="checkbox"/> Tubigrip Size _____ <b>Compression Dressing</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Grooming</b> 	<b>Hearing Aid</b> No <input type="checkbox"/> Yes Right <input type="checkbox"/> Left <input type="checkbox"/>		<b>Bed Rails</b> x 1 <input type="checkbox"/> R <input type="checkbox"/> L x 2 <input type="checkbox"/> R <input type="checkbox"/> L x 3 <input type="checkbox"/> R <input type="checkbox"/> L x 4 <input type="checkbox"/> Circle below:	<b>Alarms</b> Bed Alarm <input type="checkbox"/> Chair Alarm <input type="checkbox"/>	<b>Continenence</b> <b>Continent Urine</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Commode</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Catheter</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Product # _____
<b>Foot Wear</b> Runners <input type="checkbox"/> Slippers <input type="checkbox"/> Diabetic / Specialty Shoe <input type="checkbox"/>		<b>Shaving</b> 	<b>Dentures</b> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Partial <input type="checkbox"/>				
<b>Laundry</b> Facility <input type="checkbox"/> Family <input type="checkbox"/>		<b>Bathing</b> 	<b>Natural Teeth</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	OR 	<b>Comments:</b>		