HALIBURTON HIGHLANDS HEALTH SERVICES

Leaders in Innovative Rural Health Care

PANDEMIC PLAN

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	Executive Leadership Team	**July 7, 2022**
Approved By:	**President & CEO** **Director of Facilities & Projects**	

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Introduction

The HHHS Pandemic Plan is developed utilizing experiences captured during a world-wide pandemic which was declared in 2019 (COVID-19) and lasted for more than 2 years. Through this pandemic, many new processes were implemented to protect our Staff, Patients, Residents, Clients, and community. It is the intent to document these changes and learnings in an effort to provide a roadmap to follow for any future pandemics.

In preparation for a potential pandemic, Haliburton Highlands Health Services will prepare for and respond to a threat of influenza, COVID-19, or other pandemic that causes serious widespread illness. HHHS will take appropriate measures to minimize the impact of a pandemic. This *Pandemic Plan* recommends a series of action steps that HHHS should take in response to a potential pandemic in our community.

In the event of a novel emerging pandemic, HHHS will work with its community, regional, and provincial partners to modify its plan accordingly.

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

Definitions

Acute Respiratory Infection (ARI) – An infection that may interfere with normal breathing. It can affect just the upper respiratory system, which starts at the sinuses and ends at the vocal cords, or just the lower respiratory system, which starts at the vocal cords and ends at the lungs.

Confirmed Respiratory Outbreak –Two cases of Acute Respiratory Infections (ARI) within 48 hours with any common epidemiological link (e.g., unit, floor), at least one of which must be laboratory-confirmed;
OR
Three cases of ARI (laboratory confirmation not necessary) occurring within 48 hours with any common epidemiological link (e.g., unit, floor).

Epidemic – An epidemic is a disease that affects a large number of people within a community, population, or region.

Essential Visitor

a. a caregiver,
b. a support worker who visits a Home to provide support to the critical operations of the Home or to provide essential services to Residents,
c. a person visiting a very ill Resident for compassionate reasons including, but not limited to, hospice services or end-of-life care, or
d. a government inspector with a statutory right to enter a Long-Term Care Home to carry out their duties.

Exposure – Contamination with potentially body fluids or secretions by contact with mucous membranes, broken skin or inhalation of aerosols.

Acute Respiratory Infection (ARI) Screening – A routine process by which specific respiratory related questions are asked to Residents, Patients, Clients, Staff, or Visitors.

Hand Hygiene – Hand hygiene with liquid soap and running water (a minimum of 15 seconds contact time with soap) or use of alcohol-based hand rub (70%-90% alcohol) for 15 seconds.

Influenza-Like Illness (ILI) – Acute onset of respiratory illness with fever and cough, and one or more of the following: sore throat, arthralgia, myalgia or prostration, which could be due to influenza virus. In children under five, gastrointestinal symptoms may also be present. In persons under five or over 65, fever may not be prominent.

Isolation – Limiting a Resident or Patient's movement and social contacts when they have an active infectious disease or is the carrier of an infectious disease.

Modes of Transmission – Routes of transmission of infectious agents have been classified as contact, droplet, airborne, fomites and vector borne. Contact is the most common route of transmission of infectious micro-organisms from symptomatic or asymptomatic patients or residents. Droplet transmission is also common for patients or residents with active respiratory symptoms. Airborne occur less frequently, and vector borne transmissions are rare.

Novel Virus – A novel virus is a virus that has not previously been recorded. It can be a virus that is isolated from its natural reservoir or isolated as the result of spread to an animal or human host where the virus had not been identified before.

Pandemic – A pandemic is an epidemic that's spread over multiple countries or continents.

Personal Protective Equipment (PPE) – Equipment worn to prevent the transmission of disease while in contact with a person with a transmissible disease.

Quarantine
Separating and restricting the movement of people who are not ill but have been exposed to an infectious disease.

Routine Practices – Methods which are used regularly to protect ourselves when there is potential for contact with blood or bodily fluids. We cannot always tell if a person has an infection, so we must treat all blood and bodily fluids as potentially infectious. Bodily fluids can include feces, urine, vomit, nasal secretions, sputum, saliva, vaginal/penile secretions, wound drainage, etc.

Staff / Employee – For the purpose of this document, "Staff" or "Employee" is in reference to all workers, including Physicians, volunteers and contractors.

Abbreviations

ARI	Acute Respiratory Illness
CDC	Centre for Disease Control and Prevention
CSS	Community Support Services
HIRA	Hazard Identification & Risk Assessment
HKPR	Haliburton Kawartha Pine Ridge (District Health Unit)
ILI	Influenza-Like Illness
LTCH	Long-Term Care Home
MEOC	Ministry Emergency Operations Centre
MLTC	Ministry of Long-Term Care
MOH	Ministry of Health
MOL	Ministry of Labour
OH	Ontario Health
OHPIP	Ontario Health Pandemic Influenza Plan
PHAC	Public Health Agency of Canada
PHO	Public Health Ontario
PHU	Public Health Units
PIDAC	Provincial Infectious Diseases Advisory Committee (committee reports to the Chief Medical Officer of Health for Ontario)
PPE	Personal Protective Equipment
WHO	World Health Organization

Chapter 1 – Pandemic Planning Principles and Assumptions

Pandemic Planning Principles and Assumptions

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

Origin and Timing

- The next pandemic could emerge anywhere in the world and at any time of year.
- There may be no lead time before the novel virus reaches Canada.
- The first peak of illness in a geographic area within Canada could occur within weeks of first detection of the novel virus in that area. The first peak in mortality is expected to be several weeks after the peak in illness.

Transmission

The pandemic virus can behave like seasonal influenza viruses in significant ways:

- Incubation period
    - Is expected to last from one to three days;
- Period of communicability
    - Adults are infectious from 24 hours before and up to five days from the onset of symptoms, and children may be infectious for up to seven days. Longer periods have been found, especially in persons with immune compromising conditions;
- Methods of transmission
    - Mainly by large droplet and contact (direct and indirect) routes; the role of airborne transmission is unclear.
- Transmission is expected to be relatively lower in spring and summer than in fall and winter (the general pattern of transmission in temperate countries).
- Transmission is possible from asymptomatic persons but is greater when symptoms, such as coughing, are present and viral shedding is high (i.e., early in the symptomatic period).

Pandemic Epidemiology

- Most communities will experience two or more pandemic waves of different magnitudes. In any locality, the length of each wave will be from several weeks to a few months but may vary by community.
- There will be geographic variability with regard to the timing and intensity of waves, although multiple jurisdictions will be affected simultaneously.
- The pandemic is expected to last 12 to 18 months.
- The novel virus is expected to displace other circulating seasonal strains during the pandemic. After the pandemic, the pandemic virus will continue to circulate as a seasonal strain. It may completely replace previously circulating seasonal influenza A subtypes or continue as one of several circulating seasonal A subtypes.
- Relatively more severe disease and mortality is expected to occur in the young and in persons without underlying health conditions compared to seasonal influenza.

Clinical Features

- Population clinical attack rates (averaged across all age groups) are expected to be 25% to 45% over the course of the pandemic.
- Clinical symptoms are expected to develop in about two-thirds of people who are infected with the pandemic influenza virus.
- The general, uncomplicated clinical picture is expected to be the same as for seasonal influenza: respiratory symptoms, fever and abrupt onset of muscle ache, fatigue and headache or backache.
- Persons at high risk for complications from seasonal influenza31 are expected to also be at increased risk of severe disease and complications from pandemic influenza infection, although additional risk groups may emerge.

Impact and Interventions

- Impact will vary across communities, and vulnerable populations are expected to be affected more severely.
- Workplace absenteeism may be higher than the estimated clinical attack rate because of caregiving or concern about personal safety in the workplace in addition to worker illness.
- A vaccine is expected to be available in time to have an impact on the overall pandemic but will not be available for the first wave.
- Personal hygiene measures are expected to help to reduce transmission between individuals and within households and other settings.

The use of antivirals to decrease the risk of transmission from the first cases infected with a novel virus and their contacts will be considered as a strategy to contain or slow the spread of novel viruses that have pandemic potential and that are identified in Canada. The use of this strategy will be limited to cases identified early in the Pandemic Alert Period in Canada. During the Pandemic Period, this strategy will change to the nationally agreed upon strategy for the pandemic period.

The Ministry of LTC (MLTC) in collaboration with Ontario Health (OH) will manage pandemic vaccine supply when a pandemic vaccine is available, as well as the supply and distribution of antiviral drugs which are contained within the Provincial Antiviral Stockpile.

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

Pandemic Triggers and Typical Accompanying Actions

Public Health Actions

Trigger	Typical Actions for Consideration	Comments
Novel virus causing human cases detected somewhere in the world (no or limited transmission)	Preparations to enhance surveillance within Canada Intelligence gathering from affected areas Relevant public and health sector communications	Tailored communications to health sector and general public continue throughout the response
Novel virus with sustained human transmission detected somewhere in the world	Enhanced surveillance within Canada Intelligence gathering from affected areas; preliminary risk assessment Development of specific laboratory diagnostics Enhancement of illness prevention messages and other public health measures (e.g., hand hygiene, respiratory etiquette) as appropriate Confirmation of pandemic vaccine arrangements with manufacturer	Pandemic may be imminent or have already started
Novel/pandemic virus (with sustained human transmission) first detected in Canada	Continuation of above activities Activation of health emergency response protocols Detailed investigations of early cases to determine epidemiological and clinical characteristics and inform risk assessment Arrangements for antiviral access and strategic deployment Provision of clinical guidelines and Public Health advice	Depending on circumstances, activation of health emergency protocols might already have occurred

Trigger	Typical Actions for Consideration	Comments
Novel/pandemic virus detected in patient or local jurisdiction	Treatment of cases Ramping up health sector capacity to deal with increasing number of cases Additional public health measures (e.g., school closures) as appropriate Preparation for vaccine distribution, administration and monitoring Ongoing surveillance to monitor novel virus activity and epidemiological analysis to characterize pandemic Relevant public and health sector communications Assess need for supportive emergency and social services (e.g., reception centers, volunteers, faith-based organizations)	Escalation of activities as pandemic activity moves from sporadic cases into full pandemic wave, followed by de-escalation as it wanes
Demands for service start to exceed available capacity	Further escalation of surge capacity Prioritization or triage of services as needed Implementation of broader public health measures (e.g., banning of large gatherings)	May not reach this level in any or all jurisdictions
The pandemic wave wanes and demand for service falls to more normal levels	Preparation for a resurgence of influenza Replenishing of supplies as needed in anticipation of another wave Evaluation of response and revision of plans as required Preparation for immunization program Ongoing surveillance to detect resurgence Assessment of the psychosocial impact on the population (e.g., workforce resiliency, mental health, social cohesion) of the first wave	

Trigger	Typical Actions for Consideration	Comments
Pandemic vaccine is available for administration	Administration of vaccine as quickly as possible Monitoring of vaccine uptake, safety, and effectiveness	
Second or subsequent pandemic wave arrives	Treatment of cases Continuation of immunization if already started Ongoing surveillance to monitor novel virus activity, antiviral resistance and strain changes	
Pandemic is over and normal activities resume	Completion of pandemic studies and reports by the Executive Leadership Team in conjunction with the IPAC team Evaluation of response and revision of plans as required Return to more normal operations Preparation for post-pandemic seasonal novel virus	Identification of lessons learned and their incorporation into pandemic planning are critical activities in the recovery from a pandemic

Chapter 2 – Emergency Management Process and Response Planning

What is the Emergency Management Process?

Emergency Management is the process of dealing with and avoiding risks by identifying and managing hazards. Actions taken depend on the perceived risk of the hazard. It involves five phases:

1. **Prevention** – To avoid/eliminate disaster, as a pandemic cannot be prevented.
2. **Mitigation** – Actions taken to reduce impact of disasters or lessen impact if they do occur.
3. **Planning** – Process of developing plans of action to deal with the disaster when it occurs. Activities include identifying resources and building capacity.
4. **Response** – Mobilization of resources to respond to the disaster.
5. **Recovery** – Process to restore the affected areas back to "normal".

Effective emergency management relies on the integration of emergency plans at all levels, both vertically (e.g., provincially, locally) and horizontally (e.g., in the community).
Reference the Incident Management System Policy for further information.

Legislation during a Pandemic

During a pandemic, Haliburton Highlands Health Services (HHHS) is responsible for managing the response but will require legal authority to implement pandemic plans. Much of the pertinent legislation is already in place and is outlined in the OHPIP. Please review:

- Public Hospitals Act
- Health Protection and Prevention Act
- Emergency Management and Civil Protection Act
- Occupational Health and Safety Act
- Workplace Safety and Insurance Act
- Regulated Health Professions Act
- Employment Standards Act
- Coroners Act
- Fixing LTCH Act

Roles and Responsibilities

The World Health Organization (WHO) is responsible for coordinating a global response to a novel virus pandemic, including:

- Coordinate international response activities under the International Health Regulations
- Perform international surveillance and provide an early assessment of pandemic severity in order to help countries determine the level of intervention needed in the response
- Declare pandemic
- Select the pandemic vaccine strain and determine the time to begin production of the pandemic vaccine

Public Health Agency of Canada (PHAC) is responsible for:

- Coordinating national pandemic response activities, including nation-wide surveillance, international liaison and coordinating vaccine response.

Ministry of Health (MOH) through the Ministry Emergency Operations Centre (MEOC) is responsible for:

- Liaising with PHAC and other provinces and territories
- Developing recommendations and provincial response strategies for the provincial health system, as well as others affected by public health measures
- Communicating with provincial health system partners through various reporting methods
- Developing and issuing directives, orders and requests
- Soliciting and responding to feedback and input from provincial health system partners
- Deploying supplies & equipment from the MOH stockpile to health workers and health sector employers
- Deploying antivirals (as appropriate) from the MOH stockpile to community-based pharmacies and other dispensing sites

Public Health Ontario (PHO) (through the MEOC) is responsible for:

- Supporting the MOH to use surveillance information to determine severity
- Leading and coordinating the provincial surveillance strategy
- Coordinating and providing provincial laboratory testing
- Providing scientific and technical advice to the MOH (e.g., advice on infection and prevention control measures)
- Generating knowledge translation tools and offering training opportunities to supplement the MOH's recommendations, directives and response strategies.

Ministry of Labour (MOL) is responsible for:

- Providing Occupational Health & Safety advice to the MOH (through the MEOC)
- Enforcing the Ontario Health & Safety Act (OHSA) and its regulations

Emergency Management Ontario is responsible for:

- Coordinating the provincial response, with an emphasis on non-health system impacts and consequences

Public Health Units (PHU) are responsible for:

- Following MOH recommendations, directives, orders and requests
- Developing and issuing orders
- Leading local implementation of the surveillance strategy
- Leading local implementation of vaccination
- Participating in the coordination of local care and treatment
- Leading local implementation of public health measures

Health Liaison organizations (provincial associations, unions and regulatory bodies) are responsible for:

- Liaising between members and the MOH
- Sharing best practices among sector/membership

Health Workers and Health Sector Employers are responsible for:

- Following MOH and MLTC recommendations, directives, orders and requests
- Following PHU orders
- Continuing to provide safe and effective care
- Participating in the coordination of local care & treatment
- Participating in research and surveillance activities (as appropriate)
  Practicing and role modeling appropriate behavior to protect clients/ patients/ residents to prevent further spread of pandemic source (e.g., get vaccinated; practice personal protective strategies (mask/eye coverage, hand hygiene), stay home when sick)

Other Employers are responsible for:

- Implementing public health measures
- Following MOH and PHU orders and requests
- Encouraging vaccination among employees
- Becoming vaccinated as soon as possible

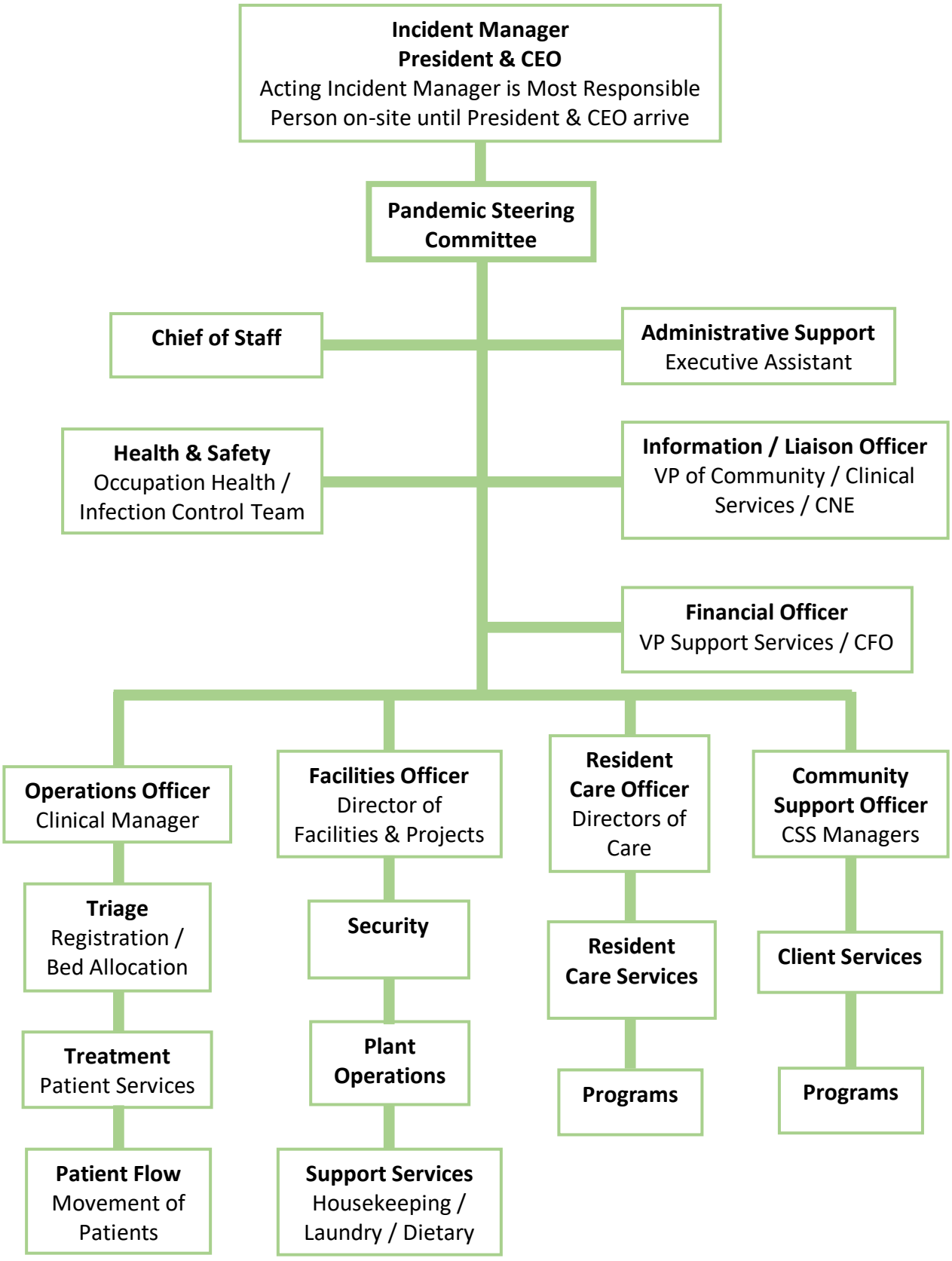
The Public is responsible for**:**

- Following public health measures such as staying home (as directed), performing personal protective measures (mask wearing, social distancing, and hand hygiene)
- Following MOH and PHU orders
- Becoming vaccinated as soon as possible

Incident Management System (IMS)

What is the IMS**?**

The IMS is a hierarchal model that provides a means to coordinate parts of one agency or many agencies in order to respond to an incident and protect life, property, and the environment. HHHS' complete IMS is located in the Emergency Preparedness & Response Manual.



Chapter 3 - Communications

Rationale

To ensure the timely and efficient flow of accurate information to guide response activities, a communications plan is required. The plan can also be used to support education and awareness needs of the hospital's target audience about the Pandemic Plan.

Goals and Objectives

The goals and objectives of the communication plan include:

- To ensure that HHHS is up to date on all relevant information.
- To identify audiences and determine their information needs.
- To establish a process to keep lines of communication open.
- To develop materials to support the communication role in the Hospital.

Flow of Communications

	Government of Canada	**Government of Ontario**	**Local Community**	**HHHS**
Key Groups	Public Health Agency of Canada (PHAC)	Emergency Management Unit (EMU), secondly Emergency Management Ontario (EMO)	Local Public Health Authorities, specifically the CDC Nurse, Representative from Municipality	OHA will serve as a liaison and act as a conduit for information conveyed to HHHS IPAC
Spokesperson	Minister of Health, Prime Minister	Ontario's Chief Medical Officer of Health, Premier of Ontario, Minister of Health and Long-Term Care, Commissioner of Emergency Management	Medical Officer of Health, mayor, municipal council head	V.P of Community Programs or President and CEO
Target Audiences	Provinces and Territories, Ministries of Health and CMOH's	Health Care stakeholders, health care workers, the public, internal government	Health Care stakeholders and workers, public and private sector	Management team, all staff members, residents, visitors, general public

	Government of Canada	Government of Ontario	Local Community	HHHS
Communication of Information	Operate a 24-hour public information line and provide updates to the provinces and territories	Use a 24-hour Information Cycle in Emergency, webpage, Important Health Notices (IHN), Directives, Fact Sheets	May use a 24-hour information cycle in an emergency	Institute: 24-hour line, Daily bulletins posted throughout Facility HHHS home webpage giving current key messages Email messages Daily updates from ICP
Trigger for Plan Activation	WHO will issue alert	PHAC will issue alert	MOH will issue alert to health system, EMO will issue alert to Municipalities	HKPR health unit will issue alert, HHHS will activate our pandemic plan
Result	Activate Government Emergency Operations Center to coordinate response with provinces/ territories	Activate Ministry Emergency Operations Center (MEOC), and potentially, Provincial EOC (PEOC) for coordinating critical infrastructure response	Activate Municipal Emergency Operations Centre, and other EOC (e.g., Hospitals)	HHHS pandemic plan will be activated, in co-ordination with HKPR Health Unit

Approach

Haliburton Highlands Health Services Community Lead (spokesperson) will work as part of the HHHS Pandemic Planning Committee to identify and plan for the communications needs of HHHS. The Community Lead may also participate on local Community Pandemic Planning Committees to address information flows in the community to the Hospital.

Responsibilities of the Community Lead in a Crisis:

- Ensure the quality of communication itself does not become the issue.
- Drive the communication process proactively rather than reactively.
- Maintain tight control over who speaks on behalf of the organization.
- Utilize the public role of the CEO to the maximum.
- Stay on message. Brief key officials rigorously prior to any announcement.
- Demonstrate caring about people. Recognize staff/public anxiety, don't dismiss it.

Tips for the HHHS Community Lead when speaking to the media:

- Be calm and confident
- Understand the medias' purpose
- Know your key messages
- Prepare carefully, know the current facts
- Be ready to answer relevant questions

Key Messages Should Express:

- Reassurance that there is a plan.
- Confirmation of known facts.
- Description of what is known and not known.
- Steps taken by HHHS to address unknowns and the impact on services.
- Statement of commitment.
- Where to go for further information.

Example of Messages for External Audiences:

- HHHS is closely monitoring the pandemic outbreak
- We have a pandemic plan in place and have activated it
- HHHS is working closely with the MOH&LTC and our local PHU to exchange information
- Current visitation policies
- Whether the LTCH is open or closed to visitors
- Types of Patients HHHS is accepting
- How to recognize symptoms of the pandemic disease
- What to do if you suspect you have the pandemic disease
- Where Patients should go if a triage center is set up in the community
- Things to do to protect public against the pandemic
- Where to go to access the latest information: (see table below)
- HHHS is committed to caring for our Staff and our community

Websites of Organizations for External Communications:

Ministry of Health	www.health.gov.on.ca/pandemic
Ontario Hospitals Association	www.oha.com
Local Public Health Unit	http://www.hkpr.on.ca/
Municipality	www.haliburtoncounty.ca

External Communication Methods and Vehicles:

Tool	Purpose	Timing
Media	To provide public with information	Daily/Weekly
Signage	To direct/redirect patients and visitors	As needed
Internet (www.hhhs.ca)	To provide public with information	Ongoing

Examples of Messages for Internal Audiences:

- Pandemic influenza has been declared by WHO
- HHHS is responding accordingly by activating our Pandemic Plan policies and procedures
- HHHS is monitoring the situation around the clock
- HHHS is in close contact with MOH, Public Health Agency of Canada (PHAC), we are following any directives for Patients, Residents, Clients, and Staff that are issued.
- The health and safety of Staff is a priority.

Internal Communication Methods and Vehicles:

Tool	Purpose	Timing
Memos for Staff	To convey timely information	As needed
Signage	For public and Staff entrances	Ongoing
Signage	For units	Ongoing
Management Meetings	To provide Managers with information, opportunities to ask questions	Daily
Talking points for Managers	To provide Managers with key messages to share with Staff	As needed
Recorded phone line messages for staff	To provide Staff members with updated information through a voice recording	Updated daily
E-mail Address	To provide Staff with a place they can email questions	Check regularly
Coffee Talk	To provide regular updates on the situation. Also, to emphasize the importance of controlling communications	Regularly
Staff Huddles	To provide updated information and reminders to Staff	Regularly

Chapter 4 – Education of Staff, Patients, Residents, Clients, and Visitors

Why is an Education Plan Necessary?

Education is a means of raising Staff awareness about HHHS' Pandemic Plan and equipping them with the skills required to respond to a pandemic.

What are the Goals and Objectives of an Education Plan?

- Ensure staff members are equipped and willing to perform their designated roles and responsibilities.
- Raise awareness of expectations of them as outlined in the HHHS Pandemic Plan.

HHHS Education Plan Prior to Pandemic

Behaviours/Skills to be trained:

- Hand Hygiene
- Cough/Sneeze Etiquette
- Proper Use of Personal Protective Equipment (PPE)
- Donning and Doffing of PPE
- Triage and resident/patient assessment
- Outbreak Management

HHHS Education Plan During the Pandemic

- Hand Hygiene
- Cough/Sneeze Etiquette
- Proper Use of Personal Protective Equipment (PPE)
- Donning and Doffing of PPE
- Self-Screening / Active-screening
- Triage and resident/patient assessment
- Outbreak Management
- General visiting guidelines
- Virtual visiting guidelines
- Designated essential caregivers
- Plan for safe social activities and outside appointments

Awareness/Information to be Conveyed

- Incident Management System
- HHHS Pandemic Plan
- Contact/Droplet/Airborne Precautions
- Benefits of Annual Flu Immunization and other pertinent immunizations
- Crisis communications

Strategies	Timeline	Responsibility
Corporate Orientation (Package and Occ Health Appointment)	On-going	Manager, HR & OHN
Annual Mandatory Education	On-going	OHN/IPAC
OH/IC Topic of the Month	As needed	OHN/IPAC
Staff Meetings, Mass emails, Zoom, Phone calls	As needed	Department Manager/OHN
Posters/brochures	Start Date	OHN/Manager
Huddles	Daily or as needed	Manager
Family Communication by mass email, phone or zoom, land mail	As needed	Director of Care/Manager

In the case a Pandemic is declared, education will be enhanced to provide the following, via technical means to maximize access and minimize contact:

- Plans, risks and responsibilities specific to provincial plans, etiology of the virus, assessment protocols for Influenza-Like Illness (ILI) symptoms, IPAC measures, OHS measures, etc.
- Reference materials covering information related to the pandemic, and reinforce practices and behaviors.
- Importance of antiviral prophylaxis and immunization, including side effects and benefits.
- Current recommendation for chemoprophylaxis using antiviral agents
- Cross-train Staff who may be redeployed
- Examples of educational resources used throughout the COVID-19 pandemic are attached at the end of this document as appendices'.

Chapter 5 – Infection Prevention and Control

How does a novel virus spread in a pandemic?

A pandemic happens when a new virus spreads to people all over the world. Because the virus is new, many more people are likely to get sick after being exposed.

Pandemic flu is not the same as seasonal flu. Pandemic flu might make people sicker than seasonal flu and might spread easily because there is no vaccine at first.

The OHPIP states that "Health care workers providing care and/or services to individuals with influenza will be at risk of exposure to the virus."

Droplet Spread

Droplet spread refers to spray with relatively large, short-range aerosols produced by sneezing, coughing, or even talking. Droplet spread is classified as direct because transmission is by direct spray over a few feet, before the droplets fall to the ground. Pertussis and meningococcal infection are examples of diseases transmitted from an infectious patient to a susceptible host by droplet spread.

Contact Spread

Direct contact occurs through skin-to-skin contact, kissing, and sexual intercourse. Direct contact also refers to contact with soil or vegetation harboring infectious organisms. Thus, infectious mononucleosis ("kissing disease") and gonorrhea are spread from person to person by direct contact. Hookworm is spread by direct contact with contaminated soil.

Airborne Spread

Airborne transmission occurs when infectious agents are carried by dust or droplet nuclei suspended in air. Airborne dust includes material that has settled on surfaces and become re-suspended by air currents as well as infectious particles blown from the soil by the wind. Droplet nuclei are dried residue of less than 5 microns in size. In contrast to droplets that fall to the ground within a few feet, droplet nuclei may remain suspended in the air for long periods of time and may be blown over great distances. Measles, for example, has occurred in children who came into a physician's office after a child with measles had left, because the measles virus remained suspended in the air.

Why is Infection Prevention and Control necessary?

To outline strategies as to how HHHS will incorporate IPAC guidelines and recommendations during the pandemic to limit transmission of the novel virus.

What are the goals and objectives of an IPAC Program?

- All health care workers should be fully knowledgeable with respect to Health Canada's "Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care."
- Routine practices are to be followed at all times.
- Equipment and surfaces contaminated with secretions from Patients, Residents, and Clients suspected to have the virus on it should be cleaned with a hospital grade disinfectant before use with another person.
- Patients, Residents, and Clients should be separated from those infected (or suspected to be infected) with the novel virus, whenever possible.

What are some Precautionary Measures?

Routine Practices	Droplet and Contact Precautions	Airborne Precautions
Wear a mask and protective eye wear when working in the Patient or Resident room or near a coughing Patient, Resident, or Client. Wear appropriate gloves when likely to have contact with bodily fluids or to touch contaminated surfaces. Wear gowns during procedures and patient care where clothing might be contaminated. Use standard operating procedures to handle, clean, and disinfect Patient and Resident care equipment, clean Patient and Resident rooms, and handle soiled linens. Prevent needle sticks/sharp injuries. Address environmental cleaning, spills management, and handling of waste.	Use examination procedures that minimize contact with droplets. Take only the equipment required to provide care into the Patient or Resident's room. When possible, use disposable equipment and discard if necessary. Remove PPE properly, wipe down areas touched by the Patient or Resident during a visit, clean and disinfect any reusable communal or shared equipment after use.	Wear a fit tested N95 mask. Perform aerosol generating procedures only when essential and in a negative pressure or airborne infection isolation room (AIIR) if available. Clean all contaminated surfaces and equipment following a high-risk procedure before leaving the room and before removing PPE.

Direction on Personal Protective Equipment for Patient Care

	Seasonal Influenza *(no risk factors for airborne diseases)*	**Pandemic Virus**	**Aerosol Generating Procedures with Pandemic Virus**
Patient Accommodation	Single patient room	Single patient room or cohort	In AIIR (airborne infection isolation room), if available.
Precautions	Droplet/ Contact	Droplet/ Contact	Droplet/ Contact/Airborne
Hand Hygiene	Yes	Yes	Yes
Gloves	Yes	Yes	Yes
Gown	Yes	Yes	Yes
Medical Mask for HCW	Yes	--	--
N95 Respirator for HCW	Not routinely	Yes	Yes
Eye Protection	Yes	Yes	Yes
Medical Mask on Patient	At triage and if outside of room	At triage and if outside of room	If outside of AIIR and if outside of room

Equipment and Supplies

During a pandemic, equipment and supplies for infection control will be in high demand. Haliburton Highlands Health Services will maintain a four-week stockpile of infection control supplies and PPE. Antiviral chemoprophylaxis will be made available through MOH if available. HHHS will have a designated Outbreak Coordinator Lead to procure supplies. IPAC will work with the Outbreak Coordinator Lead to ensure that assumptions and formulas align with IPAC guidelines and consider needs for infection control supplies, PPE, housekeeping, and linen.

HHHS (as a whole organization) maintains approximately a four (4) week supply of **Personal Protective Equipment (PPE)** as follows:

Including both LTCH's, Acute Care In-Patients and both Emergency Departments, the organization has a total of 126 resident/patient care areas. Highland Wood LTC = 30 beds, Hyland Crest LTC = 62 beds, Acute Care In-Patients = 15 beds, Haliburton ER = 7 stretchers, 3 exam rooms, Minden ER = 7 stretchers, 2 exam rooms.
Based on assumptions of all departments being at maximum capacity and 30 % (38 patients/residents) of the patients/residents are in isolation due to suspect or positive cases. All other patients are cared for while workers universally mask and use PPE based on the personal risk assessment. **Assumption of every Patient or Resident has care performed by an employee x once per hour x 24 hours/day x 30 days/month.**

Item	Amount	Calculation
Gloves	54,720 singular gloves	• 38 isolated Residents x 24 hrs x 30 days x 2 gloves
Gowns	1000 washable gowns 1000 disposable gowns as back-up and protected codes in ED	• 38 isolated Residents x 24 hrs x 30 days = 912 • Laundry is washed twice daily.
Medical Masks	3,960	• Clinical Staff in 24 hrs (66 employees) • Support Staff in 24 hrs (20 employees) • 66 Employees are given 2 medical masks for the duration of their shift. • Employees are universally masking. • 66 Employees x 2 masks/day x 30 days
N95 respirators	27, 360 (different types as per fit testing)	• 1870 + (60% of stock) • 8210 (18% of stock) • 1860 S (10% of stock) • 8511 (6% of stock) • 1860 (4% of stock) • 8110 S (1.5 % of stock) • 1804 (.5% of stock)
Eye Protection	1000 – goggles 2000 – faceshields	• Goggles are disinfected between uses and designated to an Employee / Visitor for multiple uses. • 38 isolated Residents x 24 hrs x 30 days. Faceshields are used for isolated Residents. They are disinfected between uses and discarded at the end of the shift.

HHHS (as a whole organization) maintains approximately a four (4) week supply of **Environmental Services supplies and Dietary supplies** as follows:

Based on assumptions from the COVID-19 pandemic with terminal cleaning required after any suspect/confirmed COVID-19 cases are released from isolation or discharged. This calculation is including an added 20%.

Environmental Services Supplies

Hand sanitizer refills	2 jugs x 1200 ml x 7 cases
Oxivir	2 jugs x 2.5L x 7 cases
Hand sanitizer pumps	6 x 400ml x 6 cases
Oxivir Wipes	12 per case x 3 cases
Nocolese	10L x 2 jugs

Dietary Supplies

Supplies	Calculation	Amount
Large paper plates	3/day x 126 = 378/day x 30 days	11,340 (21 cases)
Small paper plates	1/day x 126 = 126/day x 30 days	3,780 (4 cases)
10 oz paper cups	3/day x 126 = 378/day x 30 days	11,340 (11 cases)
Lids for 10 oz paper cups	3/day x 126 = 378/day x 30 days	11,340 (11 cases)
8 oz paper cups	12/day x 126 = 1512/day x 30 days	45,360 (42 cases)
Lids for 8 oz paper cups	12/day x 126 = 1512/day x 30 days	45,360 (42 cases)
Soup (lg) paper bowls	2/day x 126 = 252/day x 30 days	7,560 (7 cases)
Lids for soup bowls	2/day x 126 = 252/day x 30 days	7,560 (7 cases)
Dessert (sm) 4 ox paper bowls	3/day x 126 = 378/day x 30 days	11,340 (11 cases)
Lids for dessert bowls	3/day x 126 = 378/day x 30 days	11,340 (6 cases)
Disposable napkins	5/day x 126 = 630/day x 30 days	18,900 (6 cases)
Straws	12/day x 126 = 1512/day x 30 days	45,360 (17 cases)
Forks	3/day x 126 = 378/day x 30 days	11,340 (11 cases)
Knives	3/day x 126 = 378/day x 30 days	11,340 (11 cases)
Teaspoons	3/day x 126 = 378/day x 30 days	11,340 (11 cases)
Soup Spoons	2/day x 126 = 252/day x 30 days	7,560 (7 cases)

Food Services Pandemic Plan can be found on the HHHS Internal O:Drive at **O:\Emerging Diseases\COVID-19**

Chapter 6 – Surveillance, Screening, and Testing

What is Surveillance?

The purpose of pandemic surveillance is to provide decision-makers with the timely information they need for an effective response. Pandemic surveillance uses data obtained through routine and enhanced surveillance activities (e.g., data from sources such as laboratories, PT partners, hospital networks, and sentinel practitioners) together with information from special studies to obtain a comprehensive and timely epidemiological picture of the pandemic.

Resident Surveillance:

- Residents will be assessed for any symptoms of the novel virus twice daily with temperature checks.
- Laboratory testing will be completed at the request of the Medical Director and/or Public Health as per current guidance.
- Reporting to Public Health will be done at the request and direction of Public Health.

Patient Surveillance:

- Patients will be received through the Emergency entrance of the hospital only; all other entry points will be closed.
- Emergency department will use a screening form for all Patients (See Appendix 1 – Sample COVID Patient Screening Tool). We can expect that modifications will be made to this form relevant to the current epidemiology (type of virus).
- If a Patient fails the ILI Questionnaire, laboratory testing may be done to confirm epidemiology.
- Laboratory testing: HHHS can expect to receive instructions from Public Health on the recommended lab tests to be done (e.g., nasopharyngeal swabs, throat swabs, blood cultures). Specimens should be transported to the lab at fridge temperature of 2 - 8°C.
- Reporting to Public Health on ILI fails will be done at the request and direction of Public Health
- Patients discharged to the community will also be noted in our reporting.

Staff Surveillance:

How is surveillance data collected?

- Staff will enter at designated entrances, dependent on area/department of work and will be actively screened (LTC) or required to do a self-screening prior to entry. All other entrance/exit doors will not be used during this crisis for entry/exit. This practice will ensure that all Staff (and Visitors, if allowed) are screened and that there will be a record of Employees in the building at all times.
- If screening is deemed necessary, assessments will be done on all Staff, Patients, Residents, and Physicians, using the appropriate up to date tool. These records will be reviewed and kept on file x 30 days.
- Data will be collected by the Infection Control Practitioner and analyzed. It will be presented to the Pandemic Management Team and HKPR on a daily basis or as needed.
- The information will be used to observe the flow of the crisis in our LTCH's and hospital community, arrange for changing staffing needs, and ensure the health and safety of HHHS Employees, Patients, Residents.
- During screening there will also be an opportunity to re-educate Staff on the use of PPE, isolation precautions, and answer any questions they may have.

Diligent surveillance may reveal a "cluster":

A cluster is defined as a grouping of cases of a disease within a specific time frame and geographic location suggesting a possible association between the cases with respect to transmission. *(Annex B: Best Practices for Prevention of Transmission of Acute Respiratory Infection in All Health Care Settings; March 2013)*

Segregation and Cohorting of Residents and Patients with Suspect or Confirmed Novel Virus**:**

Each Emergency Department has one Airborne Isolation Room with ante room for PPE removal.

The process and area will be identified that would allow for this and make it possible to treat and care for Patients and Residents with pandemic virus in a self-contained area with a separate entrance, reception, screening area, etc.

Note: Detailed Floor Maps of both Haliburton and Minden sites can be found in the Annexes of the Emergency Preparedness & Response Manual and within each Emergency Evacuation Kit.

Contact/Droplet Precautions

Health care providers within one to two metres of Patients or Residents with symptoms should consistently use contact/droplet precautions in addition to routine practices:

- Wear a good quality surgical/procedure mask covering the nose and mouth as well as protective eye wear
- Perform hand hygiene using the 4 moments of hand hygiene (1. Prior to Patient/Resident environment or touching the Patient/Resident, 2. Prior to aseptic procedure, 3. After possible exposure to bodily fluids, 4. After touching the Patient/Resident or leaving the Patient/Resident environment), before applying PPE, after doffing PPE
- Use examination procedures that minimize contact with droplets (e.g., sitting next to rather than in front of a coughing Patient when taking a history or conducting an examination)
- Wear appropriate gown and gloves as per Routine Practices when the worker is likely to have contact with bodily fluids, touch contaminated surfaces, or where clothing might be contaminated
- PPE should be removed after the Health Care Provider has completed care and is more than 1 to 2 metres from the Patient or Resident

Chapter 7 – Contact Tracing, Notification, and Reporting

Responsibilities

Positive results will be reported from the reporting laboratory to the Emergency Department or Unit or Infection Control/Occupational Health, depending on whether the person being tested is a Patient, Resident, Client, Visitor or Staff member.

Emergency Department

- Will notify Patient of positive result and advise Patient (See Appendix 2 – Internal Contract Tracing & Notification)
- Will notify IPAC of result to follow up

Public Health

- Public Health will provide guidance to HHHS on current contact tracing dependent on epidemiology of novel virus.

Occupational Health Nurse

- Will follow up with any Staff member who meets the case definition of a confirmed case, probable case or person under investigation regarding return to work and contact tracing within the organization
- Will report any Staff members occupationally acquired illness to the Ministry of Labour as well as WSIB.

Infection Prevention and Control Team

- Will notify Public Health of a positive admission within the Facility and follow directives.
- Will notify Public Health of a case with a positive travel history and/or there is a possible cluster/outbreak
- Will complete surveillance on Patients and Resident's daily – (See Appendix 3 – Daily Unit Surveillance Tool)

Chapter 8 – Occupational Health & Safety

Why have an Occupational Health and Safety Plan?

To ensure that HHHS is complying with the OHSA and that every precaution is taken under the circumstances for the protection of the worker.

What is a Hazard Identification and Risk Assessment (HIRA)?

A HIRA is a systematic process to identify hazards and assess risks to eliminate or reduce the threat to workers, organizations, or systems.

Developed and published by the OHPIP, the HIRA is a useful tool for providing Hospitals with a step-by-step process of completing a worker risk assessment.

How to use it?

For each worker, ask and respond to the questions. Where the answer is "yes", the worker must be provided with education and possibly appropriate equipment and supplies.

The Assessment Questions

(See Appendix 4 – Point of Care Risk Assessment)

1. Is the worker likely to be involved in medical procedures that may result in high-risk exposures to the pandemic strain of the virus?
2. Is the worker likely to be involved in laboratory procedures that may result in a high-risk exposure to the pandemic strain of the virus?
3. Is the worker providing care and/or services to individuals with the pandemic virus?
4. Is the worker responsible for maintaining the rooms of individuals with the pandemic virus?
5. Does the worker have high frequency contact with the public?

Engineering Controls to be put in place to reduce Health & Safety Hazards

Engineering Controls	Most effective because they involve permanent changes in the workplace to reduce exposure and eliminate risk of "human-error" or non-compliance with recommended practices. They include physical barriers and hand sanitizer stations.
Administrative and Work Practices	Ways of organizing and providing care and services to reduce exposure. Consult with workers who have direct experience with tasks. They include managing Patient flows and access/egress, human resource policies, cohorting plans, and cleaning precautions.
Personal Protective Equipment	Reduce Staff exposure to hazards when engineering controls and administrative practices are not feasible or effective in reducing exposure.

HHHS Health and Safety Control Recommendations

1. Adequate staffing of IPAC and Occupation Health professionals within HHHS to conduct education and training for front line Staff.
2. A four-week supply of appropriate PPE required for routine practices, droplet precautions, contact precautions, and airborne precautions.
3. Monitor use of PPE and reinforce proper usage.
4. Maintaining a written respiratory protection program and providing fit-testing and training for Staff using N95 respirators.

   **Note: Staff required to wear N95 respirators must be fit tested and trained in the use of the respirator. HHHS must fit-test Staff with the eye protection that they will be wearing as specifications could change. A good fit can only be achieved if the area where the respirator seals against the skin is clean-shaven (beard, moustaches and stubble may cause leaks)
5. Managing a stockpile of infection control supplies (e.g., hand hygiene, disinfectants) to provide health care settings with product for weeks of a pandemic.
6. OHS will continue to track Health Care Workers (HCW) who report symptoms of the virus and follow up with reports of clusters of illness. Active symptoms and illness tracking including return to work information and vaccine and prophylaxis tracking.
7. Continue to monitor hazards and risks, reprioritize, and take action.
8. Implement policies and procedures and communicate changes to Staff, Patients Residents, Clients, and Visitors through the Communications Officer.
9. Implement an antiviral medication policy (and vaccine if available) as per HHHS strategy and monitor Staff for adverse effects and usage.
10. Evaluate and manage symptomatic health care personnel.
11. Implement time-off policies and support needs for rest and recuperation (consider those workers who live a fair distance from HHHS).
12. Point-of-care risk assessments that are carried out by individual Health Care Workers before they enter a Patient or Resident's environment or initiate care to determine the appropriate PPE, isolation, and cohorting strategies for a given Patient or Resident, during a given intervention, in a specific room, area or facility.
13. Organizational risk assessments, best carried out in the interpandemic period, to identify engineering, administrative, and personal protective equipment (PPE) controls that will best protect Patients, Residents, Clients, Visitors, and Staff in the health care setting.

14. A wide range of "source control" policies, including a 2-metre spatial separation between infected sources (e.g., Patients/Residents) and uninfected hosts (e.g., other Patients/Residents); cohorting of Patients/Residents and Staff; active admission screening; active screening of Visitors; and expanded respiratory and hand hygiene programs for Staff, Patients, Residents, Clients, and Visitors
15. Comprehensive education and training for Staff in the organization on the novel virus.

To Manage Workers with Pandemic viral Illness, HHHS uses the following guidelines:

A singular entrance/exit door will be used for Staff coming to and leaving work. Staff will be actively screened both entering and exiting the building (More information on surveillance in previous chapters)

- **Fit for Work** – Fit to work with no restrictions. Ideally, Staff are fit to work when one of the following conditions applies:
  - They have recovered from symptoms
  - They have been immunized against the pandemic strain of the virus
  - They are on appropriate antivirals

- **Unfit to Work** – Defined as a medically determinable illness that prevents an employee from performing the regular or modified duties of their occupation.

  Ideally, Staff should be considered "unfit to work" and should not work.
  - However, due to shortages, essential Staff may be asked to work if they are well enough to do so and wearing enhanced PPE as directed by the IPAC team.
  - If a Staff member becomes ill after starting their shift, they should immediately self-isolate, notify the Charge Nurse/Occupational Health and implement any Occupational Health guidance asap

- **Fit for Work with Restrictions** – Allows for the re-assignment of duties or reintegration into the workplace in a manner that will not pose an infection risk to the Staff member or to other individuals in the workplace.

  Ideally, symptomatic Staff members who are considered "fit to work with restrictions" should only work with Patients, Residents, and Clients with the same symptoms. Workers who must work with non-exposed Patients, Residents, and Clients should be required to wear a mask if they are coughing and must pay meticulous attention to hand hygiene. Symptomatic Staff who are well enough to work should not be redeployed to Long-Term Care, nurseries or units with severely immuno-compromised Patients.

Chapter 9 – Patient and Resident Assessment & Treatment

The Ontario Health Pandemic Influenza Plan (OHPIP) estimates that a pandemic influenza could result in 15-35% of the population falling ill, and most of the ill will require outpatient/primary care and 1-2% hospitalization.

The Centre for Disease Control estimates that between February 2020-September 2021 there was 25% of COVID-19 infections/illness were reported.

HHHS must be prepared to assess and manage Patients seeking medical care, along with those Employees that fall ill, or those that are being transferred out of the community.

Appropriate management of outpatient pandemic viral cases can limit the progress to severe disease and reduce the demand for inpatient care.

As the demand for care increases, ensuring that resources are used optimally and that Patients requiring more urgent care receive it first underlies the importance of accurate triage. The following are definitions of the assessment and management process:

Screening

The process of rapidly identifying individuals with criteria related to an illness with the purpose of separating Patients into groups for those with symptoms and those without.

Triage

The process of classifying Patients according to the severity of their illness in order to determine the prioritization for assessment or care based on the demand and resources available.

Assessment

The primary assessment is the process of reviewing the symptoms and vital signs. The secondary assessment (if required) follows a primary assessment and involves a thorough history and physical exam. It may also include diagnostic testing.

Discharge/Disposition

A Physician assigns Patients a diagnosis and disposition.

Management

Provide clinical management (e.g., antiviral therapy, supportive care, treatment of secondary complications).

HHHS Assessment and Management Processes

Communication

- Communicate any closures via media.

Screening

- Screening will take place at HHHS' main entrances.
- Signage directing Patients, Residents, Clients, Visitors, and Staff to any changes in procedures.
- IPAC protocols (e.g., PPE for Staff, masks and one to two metre physical distancing) will be implemented.
- Appropriate universal masking for anyone entering HHHS may be instituted.

Triage

- Triage is completed by Registered Nurses.
- Triage both pandemic and non-pandemic Patients following up to date screening.
- Continue with IPAC screening currently in practice at HHHS as well as any screening practices that are new to the novel virus.
- Triaging Patients may require full PPE for all Patients, depending on prevalence of pandemic cases within the community.

Assessment

- Primary assessment may occur outside of the hospital setting at a predetermined screening location (dependent on space and weather).
- Assessment will be performed by a Registered Nurse or Registered Practical Nurse with clinical experience.
- Additional Staff needed: Physicians and Data Entry Staff.
- Ensure those responsible for assessing Patients and making triage decisions have proper training before, and support during, the pandemic. Effective triage depends upon an established, skilled, and practiced infrastructure.
- Patients who are sent home will be provided with information including pandemic facts, self-care, and what to do if symptoms worsen.

Implementation Recommendations

- Determine which inpatient areas will be dedicated to pandemic type signs and symptoms vs. non-pandemic signs and symptoms.
- Identify any non-clinical areas of the Facility that can be converted to increase Patient capacity (designated surge area is the physio out-patient space).
- Assess the total number of Staff (Physicians, Nurses, etc.), full and part-time.
- Determine the number of Staff and supplies needed for each level of Patient assessment.
- Assess information technology support and software.
- Establish working areas that consider the following cohorting based upon: Influenza-Like Illness (ILI), Non-ILI, ILI Suspect/Exposed, ILI Confirmed, Not Exposed/Immune, Not Exposed but High Risk of Complications Assessment waiting areas.

Chapter 10 – Antiviral Drugs & Vaccines

Both antiviral drugs and vaccine therapies are part of Ontario's comprehensive strategy to minimize illness and death. While vaccines are the most effective means to prevent disease and death, it may take four to five months after the pandemic strain is identified to develop a vaccine. Antiviral drugs can be used to treat influenza and will be an important disease management strategy during an influenza pandemic – particularly during the early wave(s) when a vaccine is not available.

What is the difference between antiviral drugs and vaccines?

Antiviral drugs are a class of medication used specifically for treating viral infection. Refer to the Ontario Health Pandemic Influenza Plan (OHPIP) for a list of antiviral drugs that are currently approved in Canada. Several different types of treatments for COVID-19 have been developed. Examples include drugs that reduce or stop the virus from multiplying in human cells and drugs that treat the symptoms of COVID-19.

A vaccine is a preparation that contains antigens consisting of whole viral organisms (killed or weakened) or parts of such organisms, and is used to confer immunity against the disease that the organism causes.

For Heath Care Workers:

HHHS believes that the use of antiviral prophylaxis for the protection of health care workers is an important strategy to keep the Organization's services functioning during a pandemic. The MOH will make antivirals available dependent on the type of novel virus causing the pandemic. The most common antiviral for influenza pandemic is called "Tamiflu". Other drugs are also being considered for use, such as "zanamivir" (Relenza).

Several different types of treatments for COVID-19 have been developed. Examples include drugs that reduce or stop the virus from multiplying in human cells and drugs that treat the symptoms of COVID-19.

Health Canada has authorized Remdesivir (veklury); bamlanivimab; casirivimab and imdevimab; Sotrovimab; nirmatrelvir and ritonavir (paxlovid™); tixagevimab and cilgavimab (evusheld™) as COVID-19 antiviral treatments. These treatments are available for provinces and territories to use in their health care systems. Each province and territory is determining the appropriate administration of these drugs based on their needs.

When a Pandemic is declared, HHHS will be receiving updated information from Public Health on which antiviral is recommended.

For the General Public:

HHHS will also work with the local Public Health Unit (PHU) to determine who is responsible for receiving and managing the MOH antiviral drugs stockpile for the community. We will confirm how the hospital will access these medications, and in what quantities, for treatment of Residents and Patients at HHHS.

Annual Influenza Vaccination

HHHS has a current policy regarding Staff Influenza Vaccination. Annual influenza vaccination is highly recommended for all Employees, Students, Volunteers, and those on placement at HHHS. Valid medical exemption: vaccine should not be given to persons who are known to have serious adverse reaction to the vaccination (see policy). Staff will be offered this vaccination at HHHS' expense, to this end, flu vaccination clinics are held every fall for the immunization of our Staff. *Link to influenza vaccination policy*

COVID Vaccination

The most up-to-date Policies and information regarding COVID-19 can be found on the HHHS internal O:Drive, located under Emerging Diseases/COVID-19.

The National Advisory on NACI recommends that:

1. Individuals who are at increased risk of severe illness from COVID-19 should be offered a fall COVID-19 vaccine booster dose* regardless of the number of booster doses previously received, including:
    - Older adults (≥65 years of age)
    - Residents of long-term care facilities or congregate living settings for seniors
    - Individuals 12 years of age and older with an underlying medical condition that places them at high risk of severe COVID-19
    - Adults in or from First Nations, Métis, or Inuit communities, where infection can have disproportionate consequences
    - Adults in racialized communities and marginalized communities (e.g., people living with disabilities) disproportionately affected by COVID-19
    - Residents of other congregate living settings (e.g., quarters for migrant workers, shelters, correctional facilities, group homes) who are 12 years of age and older *(Strong NACI Recommendation)*
2. All other individuals 12 to 64 years of age maybe offered a COVID-19 booster dose* in the fall of 2022, regardless of the number of booster doses they have previously received. *(Discretionary NACI Recommendation)*
3. COVID-19 booster doses may be offered at an interval of 6 months since a previous COVID-19 vaccine dose or SARS-CoV-2 infection. A shorter interval of at least 3 months may be warranted in the context of heightened epidemiologic risk, as well as operational considerations for the efficient deployment of vaccine programs. *(Discretionary NACI Recommendation)*

Chapter 11 – Essential Services

Why is an Essential Services Plan Necessary?

To outline strategies for building surge capacity and utilizing a phased approach to scaling back services to ensure that Essential Services are available for both novel virus Patients and non-novel virus Patients, and that the safety and protection of Staff are not compromised.

Goals and Objectives

The goals and objectives of the HR plan include:

- To ensure that plans will be coordinated and systematic so that HHHS can continue to provide essential services.
- To plan for specialized populations in conjunction with the larger community hospitals and resources in the region.

Prioritization of Services

The prioritization of services considers the following three elements:

- Level of Urgency
    - **Level 1** – Must do, cannot be deferred or delegated
    - **Level 2** – Do not defer if possible or bring back as soon as possible
    - **Level 3** – Can be deferred, medium-low priority
- Surge Level Experienced
    - **Minor Surge** – an enhanced surge strategy to respond to a 5-10% increase in demand compared to normal
    - **Moderate Surge** – an augmented surge strategy to respond to a 11-15% increase in demand compared to normal
    - **Major Surge** – an optimal surge strategy to respond to a 16-20% increase in demand compared to normal
    - **Large Scale Emergency or Extreme Surge** – an overcapacity surge strategy to respond to over 20% increase in demand compared to normal
- Level of Response
    - **Hospital Response** – considered to be minor and moderate surges requiring coordination and allocation of resources at the hospital level
    - **Regional Response** – considered to be major surges requiring coordination and allocation of resources at a community/regional level
    - **Provincial Response** – considered to be a large-scale emergency requiring coordination and allocation of resources usually at the provincial level

HHHS Programs and Services

Clinical Services

- Services or procedures providing comprehensive therapeutic care to meet a variety of patient care needs.

Clinical Support Services

- Services that provide a range of allied health and administrative functions both directly to patients and as support to the clinical and administrative services.

Administrative Services

- Services that support the decision-making needs and operational needs of the hospital.

Prioritization of HHHS Programs and Services

	HHHS Program or Service	**Level 1** Cannot be deferred or delegated	**Level 2** Do not defer if possible or bring back as soon as possible	**Level 3** Can be deferred, medium-low priority
Clinical	Emergency	✓		
	Acute Care	✓		
	Long-Term Care	✓		
Clinical Support	Physiotherapy		✓	
	Diagnostic Imaging	✓		
	Lab	✓		
	Reprocessing	✓		
	Housekeeping	✓		
	Dietary	✓		
	Laundry	✓		
	Maintenance	✓		
	Diabetes Education		✓	
	Activity Programs		✓	
	Volunteers			✓
	Hairdressing			✓
Community Support Services	GAIN	✓		
	Mental Health	✓		
	Adult Day Program	✓		
	Supportive Housing / Assisted Living	✓		
	MOW	✓		
	Transportation	✓		
	Social Recreation		✓	
	Security Checks	✓		

	HHHS Program or Service	Level 1 Cannot be deferred or delegated	Level 2 Do not defer if possible or bring back as soon as possible	Level 3 Can be deferred, medium-low priority
	Hospice	✓		
	Emergency Response System	✓		
	Enhanced Care Coordination		✓	
	Brokered Worker			✓
	Home Help Maintenance			✓
	Friendly Visiting		✓	
	Nursing Foot Care			✓
	Cancer Care & Bereavement Support Group		✓	
Administrative Support	Finance	✓		
	Business Office	✓		
	Health Records	✓		
	Human Resources	✓		
	OH/IPAC	✓		
	Foundation Office		✓	
	Gift Shop			✓

Plan for Surge Physical Capacity

Surge Levels During Pandemic		Surge Strategies	Response Level	IMS Command Function
Pre-Surge	Basic	Staffing and operational beds open Some approved beds closed due to resource constraints	Intra facility	HHHS
Minor Surge 5% - 10%	Enhanced	Cohort/isolate novel virus patients in ER and acute care unit	Intra facility	HHHS
Moderate Surge 11% - 15%	Augmented	Establish early discharge; home care transfers; ALC transfers to LTC Defer some treatment for non-life threatening condition if no severe adverse health consequences anticipated from the delay	Intra facility	HHHS
Major Surge 16% - 20%	Optimum	Defer all treatment for non-life threatening condition if no severe adverse health consequences anticipated from the delay	Inter facility	Region Province
Large Scale Emergency > 20%	Over Capacity	No more beds available Maintain services for life-threatening conditions Triage for all treatment Mass emergency care	Inter facility	Province

Activating Responses

Upon implementation of the IMS, the Incident Manager will coordinate and initiate prioritization of services based on the following information:

- Surveillance reports
- Infection Prevention and Control data
- Occupational Health & Safety information
- Human resources available
- Equipment and supplies on-site/accessible
- I.T. data:
    - Number of Emergency Department visits
    - Admission rates
    - Staffing levels
    - Bed usage and types of beds
    - Ability to manage access to care based on security support

Chapter 12 – Human Resources Plan

Why is a Human Resources Plan Necessary?

To develop strategies to optimize the availability of human resources to meet demands for provision of services and continuity of operations.

Goals and Objectives

The goals and objectives of the HR plan are to ensure that management is knowledgeable about the Occupational Health & Safety Act as well as about rights of the employer/workers and collective agreements and to maintain adequate staffing levels to manage the existing and additional workflow resulting from the pandemic event.

Key Assumptions

The Human Resources Plan for a pandemic situation has been developed based on the following assumptions:

- There will be limited warning of oncoming pandemic incident, thereby reducing planning time.
- Absenteeism due to illness will be extensive, difficulty maintaining staffing levels.
- The pandemic event may have several waves, each one being more severe. Therefore, HR planning must recognize both short-term and long-term strategies.
- Other hospital and LTC clinical work must continue.

Organization Resiliency – Mental Health & Wellness Supports

- Employee Assistance Program (Homewood Health) can provide services during a pandemic event
    - Staff Stress Management
        - **Homewood Health** is the external provider for group Staff stress management sessions and team critical incident debriefing in the event of a declared organization-wide crisis. In the event of a declared organization-wide crisis, Human Resources will take requests from departments and coordinate crisis-related Warren Shepell stress management services for groups and teams. It is hoped that, with timely implementation of a stress management response, Staff will be more resilient.
    - Patients & Residents Stress Management:
        - **ORAK**: Ontario Residents Association Council will be resourced.

Compensation and Benefits

- Provisions in Collective Agreements for compensation and benefits must be upheld (for both internal and external hires).
- Staff will not be paid additional compensation outside the existing Collective Agreements for working during the pandemic, unless directed through the MOH.

General Strategies to Optimize Staffing Capacity

- Re-deploy Clinical Staff from deferred services.
- Defer Staff holidays and Leaves of Absence until pandemic ends.
- Revise Staff schedules to increase shift length or number of days worked, within parameters of Collective Agreements.
- Train non-clinical Staff to provide support services such as meals, personal care, and Patient or Resident movement for treatment, site cleaning, and support for Health Care Workers and their families so that workers can do their job (e.g., child care, pet care).
- Recruit clinical agency Staff in coordination with other health care facilities or agencies.
- Encourage members of the public to take home health care courses before the pandemic so they know how to prevent infection and provide supportive care for family members who are ill; train family members of hospital Patients to provide home health care.
- Cross-train Clinical Staff for care related to the pandemic virus and other essential services during a pandemic and other large-scale emergencies.

Essential Competencies and Inventory of Staff Skills

Based on the prioritized services in previous chapters – Essential Services of the plan, Staff competencies need to be determined related to the Hospital services which are not deferred. To achieve, Staff in Level 2 and Level 3 services are surveyed to obtain competencies which are required for Level 1 services. (Reference back to relevant page)

Redeployment Centre

The Redeployment Centre will be organized and set-up very quickly, within 24 hours, due to lessons learned during COVID.

- Redeployment Principles and Operational Guidelines for redeployment will be established
- The hospital has determined which services are essential and which could be classified as non-essential (see Essential Services). This will assist the Redeployment Centre in reassigning work. It must be understood that if Staff are not doing essential work related to the pandemic or other critical functions, they must be redeployed.
- Additional payroll codes will be set-up to designate hours worked due to redeployment.
- Redeployment Centre will have the ability to capture, monitor, and track all redeployment activities from the beginning of the assignment to the conclusion.
- Staff cannot volunteer to be redeployed or do extra shifts unless approved by a Manager.
- A weekly list of redeployed Employees will be produced so that tracking is efficient.

Redeployment Centre Structure

- The redeployment office will be located in the Human Resources area.
- An e-mail address will be created to allow Staff to communicate if they are available for redeployment.
- A telephone extension will be dedicated for Staff to call in availability for redeployment.
- Signs will be prepared to identify the physical location of the Redeployment Centre.
- The hours of operation for the Redeployment Centre and staffing levels needed based on operational needs will be posted.
- Communications to all Staff advising of the Centre location and “how to” contact by phone and e-mail will be developed.
- Type of tasks required and the numbers required to fill those jobs will be developed. Templates for redeployed shifts will be prepared based on those staffing requirements.
- Departments with Staff who are available to be redeployed will be identified.
- A report from the payroll system listing casual Staff will be developed.
- A “Cost Centre” number will be created so that the cost of the redeployment can be monitored.
- Redeployment will consult with a Manager/Supervisor/Clinical Staff member if there are Nursing Staff to be redeployed.

Recruitment Plan

Maintaining adequate staffing levels is the primary concern during a pandemic. With Staff ill and an expected increase in Patients, having enough Staff to provide regular services will be problematic. However, the Organization will be expected to continue providing services to Patients, Residents, and Clients. The recruitment plan includes the following:

- Prior to pandemic event, recruit additional casual and part-time Staff (full-time Staff if approved) to provide extra coverage.
- Recruit retired Staff back into service.
- Recruit students from all clinical and healthcare related programs, nursing schools, interns, residents, etc.
- Recruit external people into non-clinical positions and redeploy internal Staff into positions that require health care knowledge.
- Use existing agencies and Agency Staff.
- Recruit family members from Staff to assist with non-clinical work.
- Recall Staff from vacations, Leaves of Absence, etc. (labour relations implications)
- Can go to EI office to mass recruit if unskilled workers are required.
- Compensation must be aligned with Collective Agreements and hospital practice.

Use of Volunteers

HHHS may require the services of every Volunteer in order to meet our service demands during a pandemic event.

Budget Tracking – Special Codes & Cost Centres

To assist with tracking expenses, Finance & Payroll should be prepared to assign special codes or tracking mechanisms for items related to a pandemic event.

- Sick time related to the pandemic will be coded separately. Payroll will be consulted.
- Redeployment must be tracked through the originating department with a special code.
- Other special codes could be assigned as system allows or as needed.
- Finance & Payroll will develop further tracking plans.

Labour Relations – Union Expectations

HHHS preparedness plans will be proactively discussed with all unions prior to the event. During a pandemic, unions will receive regular updates.

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Shared Health. 2021. *Provincial Long-Term Care/Personal Care Home Pandemic Plan*. https://www.sharedhealthmb.ca/files/provincial-ltc-pandemic-plan.pdf

CDC. 2012. *Principles of Epidemiology in Public Health Practice – Section 10: Chain of Infection*. https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section10.html

Appendix B: Provincial Case Definitions for Diseases of Public Health Significance https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/respiratory_outbreaks_cd.pdf

Ontario Science Advisory Table – Drugs and Biologics Clinical Practice Guidelines Working Group, Ontario Science Advisory Table Congregate Care Working Group and LTC+ *Therapeutic Management of Residents of Long-term Care Homes with COVID-19*

I am sick – What do I do file:///O:/Emerging%20Diseases/COVID-19/Occ%20Health%20Info/What%20to%20do%20when%20Im%20sick%20January%2021%202022.pdf

LTC Staff – What to do if exposed or positive to COVID-19 file:///O:/Emerging%20Diseases/COVID-19/Occ%20Health%20Info/LTC%20STAFF_What%20to%20do%20when%20EXPOSED%20or%20POSITIVE%20January%2031%202022.pdf

Hospital & Community Staff – What to do if exposed or positive to COVID-19 file:///O:/Emerging%20Diseases/COVID-19/Occ%20Health%20Info/HOSP%20COMMUNITY%20STAFF_What%20to%20do%20when%20EXPOSED%20or%20POSITIVE%20January%2021%202022.pdf

COVID-19 self-screening for Hospital & Community Staff file:///O:/Emerging%20Diseases/COVID-19/Screening%20Tools/Staff%20Visitor%20Physician%20Screening%20Tools/Staff%20physician%20visitor%20HOSPITAL_COMM%20COVID%20Screening%20May%204%202022.pdf

National Advisory Committee On Immunization (NACI) Statement of June 29, 2022 https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/naci-summary-june-29-2022.pdf

Appendix 1 – Sample COVID Patient Screening Tool

Chest Pain? □ Shortness of Breath? □ Severe allergy? □

If yes to any of the above, immediately notify nurse of patient arrival! Time:_____

Patient is unable to answer questions □
If a Patient is unable to answer questions due to level of consciousness / ability or subjective pain level, care for the Patient as if a "failed screen" and notify the nurse.

1. Do you have any **one** of the following symptoms?
   - □ Fever (37.8 C or greater) and/or chills
   - □ New/worse cough
   - □ Shortness of breath
   - □ Decrease or loss of sense of smell
   - □ Sore throat
   - □ Runny nose/nasal congestion
   - □ Vomiting or diarrhea
   - □ Unexplained abdominal pain
   - □ Headache
   - □ Unexplained extreme fatigue
   - □ Muscle aches/joint pain
   - □ New/worse/unexplained bruising, hemoptysis, rash

No □ Yes □

(If the individual experiencing symptoms received a COVID-19 vaccine in the last 48 hours and is experiencing mild headache, fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No")

High-Risk Contact screening questions:

2. In the last 10 days have you been confirmed to have COVID-19 **or** had close unprotected contact with a confirmed case of COVID-19

No □ Yes – self, confirmed □ Yes – self, close contact □

3. Have you travelled outside of Canada or been in contact with a **sick** person who has travelled outside of Canada in the last 21 days?

No □ Yes □

4. Do you live in a congregate living setting that is currently on COVID-19 or respiratory outbreak, such as LTC, Retirement Home, Shelter, Group Home etc

No □ Yes □

5. Do any of the following apply?
   - You live with someone who is currently isolating because of a positive COVID-19 test
   - You live with someone who is currently isolating because of COVID-19 symptoms
   - You live with someone who is waiting for COVID-19 results

No □ Yes □

6. Are you vaccinated for COVID-19?

No □ Partial □ Yes □

If the patient answers YES to any of the above questions they have failed the screening

Circle One: Passed Failed

PASS Screening- Advise the patient to apply ABHR, put on a medical mask, wait in the waiting area and advise the triage nurse immediately if their condition changes.

FAILED Screening- Advise the patient to use the ABHR, put on a medical mask, wait in the waiting area and advise the triage nurse immediately. Any patient who fails the COVID-19 screening is to be cared for on droplet/contact precautions.

Notify the Nurse immediately if the patient requires assistance –

Screener Initials_____

Appendix 2 – Internal Contact Tracing & Notification

Positive COVID-19 Result – HHHS Internal Contact Tracing		
Circle One: Patient Staff Resident Client Physician		
Name:	Phone Number:	
Department:		
Date of Admission (Patient) or Last day worked(Staff):		
Date Droplet Contact Isolation was initiated:		
Symptoms:		
Date of Symptom Onset:		
Asymptomatic (list reason for swab):		
Date COVID-19 Swab was obtained:		
Did the lab request a repeat swab?:		
Resident/Patient Location: (room/ bed number)		
Did the Patient/Resident/Staff transfer to any other location/department within 14 days of the positive result? List all locations and dates (within HHHS only, HKPR will do external contact tracing):		
Date	**Location**	
Room Mate/ Table Mate/ Close Contacts (co-workers)/ Visitors within 14 days of positive result:		
Date	**Name**	**Contact Number**
Name of person who completed this form:		
Date and time positive result was received:		
IPAC Signature:		**Date:**
Forwarded to Department Manager:		**Date:**
Please scan completed form to aprentice@hhhs.ca After hours and weekends please ALSO scan to hhhsmanager.oncall@hhhs.ca		

FOR IPAC USE ONLY	
IPAC Contact tracing	
Patient Name:	
DOB:	Male Female
MRP:	Ordering Physician:
Symptomatic: Yes No	Symptoms:
Date of Admission:	
Date Droplet/Contact Isolation was initiated:	
If applicable: Dates that Patient was not in droplet contact isolation (contact tracing required):	
Date COVID Swab obtained:	
Results: Positive Negative Date:	
Repeat swab advised by lab?	
Patient / Resident Location (room number):	
List all locations Patient/Resident has occupied during admission (include ER/ Xray):	

If POSITIVE Patient is a Staff member or Physician list all locations and dates they have worked
SYMPTOMATIC: 14 days prior to symptoms
ASYMPTOMATIC: 48 hours prior to swab being obtained to current date:

Location	Date

Manager of each department will be notified by IPAC or covering manager to notify Staff members of possible contact.

List of Managers contacted to conduct Staff notification of a positive COVID encounter

Manager	Date

Departments to consider for contact tracing: Nursing, DI, Physicians, Lab, Housekeeping, Physio, Laundry, Maintenance, Registration Clerk, Observers, Screeners, Activities, Dietary, EMS/OPP

DIRECTION FOR Manager On Call IF POSITIVE COVID 19 NOTIFICATION AFTER HOURS

Step 1.

- Review the notification process algorithm with the Nurse

Step 2.

- If required, assist nursing staff to complete internal contact tracing report (this may be required depending on current volume in department)

Step 3.

- Notify department Manager, IPAC and CEO via email for follow up during business hours.

Script for Nurse/Physician to follow when advising patient of positive COVID-19 results

Hi [Patient name],

This is [Nurse/Physician name] from the Haliburton/Minden Emergency Department. I am calling to inform you that your COVID-19 swab taken [date swab was obtained] has come back POSITIVE for the COVID-19 virus and I wanted to provide you with some follow up information. People with mild symptoms of COVID-19 who are otherwise healthy should be able to manage their symptoms at home. You will need to self-quarantine for the next 14 days, if your symptoms get worse please contact your family physician or present to ER.
Public Health will be in touch with you soon to gather information from you that will assist them in conducting contact tracing. Anyone you reside with or have had close contact with over the last 14 days should be self-isolating and monitoring for symptoms of COVID-19. They are encouraged to call the assessment centre and book an appointment for COVID testing. Public Health will provide further information about this. If you have a family physician at the HFMC someone from there will be in touch with you. If your family physician is not local, please contact their office and advise them of your positive result.

I know this is a lot of information to take in, you will have further opportunity to ask questions when public health reaches out to you. If you have access to the internet I recommend going to the Haliburton Kawartha Pine Ridge District Health Unit Site (HKPR.on.ca) for information. Do you have any immediate questions about COVID-19?

NURSES: If patient has further questions regarding their condition or health please advise them that you cannot provide advice over the telephone and encourage them to contact their family physician.

If the patient has questions about COVID please use this information as a guide:

All About COVID-19:
On average it takes 5–6 days from when someone is infected with the virus for symptoms to show, however it can take up to 14 days.
Some of the most common symptoms of COVID-19 include; fever, dry cough, and tiredness. The less common symptoms: aches and pains, sore throat, diarrhea, conjunctivitis, headache, loss of taste or smell, a rash on skin, or discolouration of fingers or toes. Serious symptoms include: difficulty breathing or shortness of breath, chest pain or pressure, loss of speech or movement. Please seek immediate medical attention if you have serious symptoms.

COVID-19 spreads between people through direct, indirect (through contaminated objects or surfaces), or close contact with infected people via mouth and nose secretions. These include saliva, respiratory secretions or secretion droplets. These are released from the mouth or nose when an infected person coughs, sneezes, speaks or sings, for example. People who are in close contact (within 1 metre) with an infected person can catch COVID-19 when those infectious droplets get into their mouth, nose or eyes.

To avoid contact with these droplets, it is important to stay at least 1 metre away from others, clean hands frequently, and cover the mouth with a tissue or bent elbow when sneezing or coughing. When physical distancing (standing one metre or more away) is not possible, wearing a fabric mask is an important measure to protect others. Cleaning hands frequently is also critical.

Appendix 3 – Daily Unit Surveillance Tool

Appendix 4 – Point of Care Assessment

Point of Care Assessment (April 2021)

ASSESS the TASK, the PATIENT and the ENVIRONMENT Prior to EACH PATIENT INTERACTION

Performing a **PCRA** is the first step in routine practices.

Routine Practices are to be used with **all patients** for **all care** and **all interactions.** This will help you decide what, if any, **PPE** you need to wear to protect yourself and to prevent the spread of germs.

A **PCRA** is to be performed prior to contact with every Patient, every time even if the Patient has been placed on **Additional Precautions** as more PPE may be required.

Will my hands be exposed to BBF[2] or contaminated items?	Will my clothing or skin become soiled from splashes/sprays or contact with items contaminated with BBF[2]?	Will my eyes or face or mucous membranes be splashed or sprayed with BBF[2]or within 2 meters of coughing or vomiting patient?
YES	**YES**	**YES**
Wear Non-Sterile Gloves 	Wear Gown 	Wear Facial Protection (Mask & Eye) 

Perform Hand Hygiene before and after PPE use

Refer to Donning & Doffing posters for correct order for putting on and removing PPE & hand hygiene steps

Notes

[1]**Environment** = any area within 2 meters of the patient as well as their belongings and bathroom or the immediate space around a patient that may be touched by the patient AND may also be touched by the healthcare provider when providing care or performing tasks

[2]**BBF** = Blood and Body Fluids (includes: urine, feces, wound drainage, saliva, vomit, CSF, sputum, nasal secretions, semen, vaginal secretions)

Patient = Refers to any patient, resident, client or any other person

Adapted from Choosing Personal Protective Equipment (PPE) 2014

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